Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For AMEND#10E Per FH State of Maryla State of Maryla Registrar 3/14/08 AACO HEALTH DEPT. OMH Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Michael Joseph Connelly 11:30p ^M March 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 761 Dividing Road Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29,1929 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F 78 Director 356-24-5718 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 765 Dividing Road USA 21146 761 Dividing Road Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: \$ Korea 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other this any injury or other trailmastic Journalist Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Joseph Connelly, Sr. Sarah Kuczinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle L. Dilks/Daughter 640 22nd Street South Arlington, VA 22202 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 17, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Millersville, MD Our Lady of the Fields 2008 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) Physician Tole No Carcinoma ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the t use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy φ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed certificate 21 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Seath 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

5

31. Date filed (Month

Day, Year)

MAR 1 4 2008

DHMH 17 Rev 1/2001

ORIGINAL

//6

egistrar's Signature

08-02227 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jennifer Lynn Dollard State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 20, 2008 Medical Examiner 0941 hrs Jennifer Lynn Dollard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3708 Ramsev Road Edgewater Anne Arundel 5. Social Security Number 6 Sex If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year Director 303-72-6687 Country) Indiana 2 X F М 50 8/25/1957 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Marvland Anne Arundel Edgewater 23a or 28a-f show notified at once, 1 Yes 2 X No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3708 Ramsey Drive 21037 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 9 3 X Widowed If Yes, Giva Yee 1 Yes 2 X No specify: 4 Divorced White Specify: "natural". þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed timore, MD 21215-0036

.. Pages 1 and 2 should be filed within 72 hos ment of Health and Mental Hygiene.
-tant: If item 27 is marked other than "mar or other traumnite event, the Medicial Exp. Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Homemaker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Swain Be Ruth Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica A. Dollard/ Daughter 3708 Ramsey Dr., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: I Arlington Natl. Cem. 4/21/08 Donation 5 Other Specify: Arlington, VA 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fun Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Fentanyl intoxication Immediate Cause (Final disease `**⊊**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - transi Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/4/08 amh X UNPENDED of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 2 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Division Natural Pending Fnd at 9:00 am filled in by the 3/20/08 Unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 2708 Ramsey Rd. Edgewater. MD (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 21, 2008 30. Name and address of person who completed cause of death (Item 23a)

Registrar
DHMH 17 Rev 1/2001

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

2008

Tasha Greenberg MD.

31. Date filed (Month, Day, Year) MAR 2 6

Assistant Medical Examiner

Pleasen Type of Print, in Black Indelibie lak 1 From re All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:30 PM 2008 03 13 RUBENI DIAZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 5. Social Security Number Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/15/1950 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 217-15-3505 ElSälvador Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MDMontgomery Sandy Spring 1 ∐Yes 2 XINo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1806 Olney Sandy Spring Road 20860 El Salvador Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ Yes 2□No Flscalvador 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Never Married 2 ☐ Married White þ ear or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Grocery Store 18. Mother's Name First Middle Perfecta Diaz 17. Father's Name (First, Middle, Last) Be Unknown Porfirio Urias Maria Diaz ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2018 60 19a. Informant's Name/Relationship (Type. Print) 1806 Olney Sandy Spring Rd Sandy Spring, MD Dolores Sorto Turcios/Niece Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Amonal from State 1🔼 Burial 2 □ Cremation Pasqina Cemetery 3/23/2008 La Union, El Salvador 4 □ Donati 5 Other (Specify) 21. Signature f Funeral Service PHILIPAdes RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequend of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and stran tran Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 2/2/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Hnpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, hours after death.

Certification: To within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEUTEMI 2 South 31. Date filed (Month, Day, Year) MAR 18 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 10g per FH 04/00/20108ted tok Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SHANTABEN N. DAVE MARCH 2008 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2179 RICHLAND COURT WALDORF CHARLES If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2√F 83^{Yrs} 218-39-2006 Director JUN.10,1924 INDIA Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d Inside City Limits "natural", or Items 23a or 28a-f show drai Examiner must be notified at 1 ☐ Yes 2 X No Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2179 RICHLAND COURT U.S.A. 20601 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married ☐ Yes 2 🔀 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: ASIAN \$ 3 ₩ Widowed 4 Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) filed withii Hygiene. AT HOME HOMEMAKER 4 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental GOMTIBEN TRIVEDI SHIVSHANKER TRIVEDI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is any Injury or other trau PRABODH DAVE / SON 2179 RICHLAND CT. WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MARCH 6, 2008 4 ☐ Donation 5 ☐ Other (Specify) BRINSFIELD-ECHOLS CHARLOTTE HALL, MD 21. Signature of Funeral Service Licenses RAYMOND FUNL. HME., P.A. 1800 0 5635 WASHINGTON AVE., LA PLATA, MD20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Fibrillation **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disp to for as a portsea Examiner be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical certificate the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant the death 3 ☐ Ectopic pregnancy ę in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 1□ Yes 2 **X**(10 Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral direction ٩ 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Leath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation (Month, Day Year) within 24 hours after community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057999 08

State

JARIWALA, MD.

egistrar's Signature

11637 Terrace Drive, waldorf, MD20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANISHA

31. Date filed (Month, Date Year)1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MAE DRUMMOND 9:45 A M ARVIS 3 5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice at Lak bu lis comico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2124 F 26-38-8350 3-1943 Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1XYes 2 No MARYLAND Wicomico SALISBURY Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? NAYLOR Mill 215 21801 29339 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Be Completed by 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Domestic NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARVIG SONES SUSIE CHNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29339 Naylor Mill DRUMMOND Re SAlis. Md. 21801 HUSBANG SAAC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State F)CRES 3-21-08 Salisbury, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Solic Mi var DEWAR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST METASTATIC CARCINDMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed?
Yes 2 No certificate has 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title propertifier 00058410 03-15-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL HOSPICA 108 32 Begistrar's Signature PUBOX 1733 SALISBURY MD 21802

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Physician Mary Fertitta March 2008 1:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 866 Shore Acres Road Arnold 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
_____ 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Months 1 □ M 2 🔀 F 97 Dec. 8, 1910 Director 214-74-2286 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at MD Anne Arundel Arnold 1 ☐ Yes 2 🙀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 866 Shore Acres Road 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: Specify: White \$ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Dominic Tamburo Josephine Pedi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau once. Neal V. Fertitta/Son 866 Shore Acres Road Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 17, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 4 Donation 5 Dother (Specify) 2008 Baltimore, MD 22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service Dicenses P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate ause (Final disease condition in death) Due to (or as a consequence of): **Physician** /Medical Examiner drtero sclevoti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 700 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 L Natural death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 🖵 🚾 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar

1509 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avust Avust &

2008

016964

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	aryland		rtment of H tificate of I		nd Me	ental Hy	gien Reg. N		10507	
			Decedent's Name (First,	Middle, Last	")						2. Date of De		ay Year	3. Time of Death	
	Physicia /Medic		Eloise Pet	terson	Furber					M	larch_	15.	, 2008	5:40AM ^M	
>	Examin	er	4a. Facility Name (If not ins	stitution, give	street and number)			4b. City, Town, or		Death			tc. County of Death		
Ļ			Casey House 5. Social Security Number	e 6. Se	7 40	o (In ure la	ıst birthday)	Rockvil If Under 1 Year	1e If Under 24	4 Hrs.	8. Date of Bi		Montgomer		
	Funeral Director		480-32-4586	1[M 2X F 7. Ag		8 Yrs.	Months Days	Hours	Min.	Sept. 2	ay, Yea			
	land t		Usual Residence of Deceder 10a. State 10b. C	ent County		10c. City,	Town or Loc	cation			-			10d. Inside City Limits	
	Mary -f sho	tor	Md. M	lontgon	nery	Beth	nesda							1 Ves 2 No	
	h the	Director	10e, Street and Number		-			10f. Zip Code				10g. (Citizen of What Co	untry?	
	th wit		5106 Newport	t Ave.					2081	16			USA		
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origi an, Mexican,	in? (Spec Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White		
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2[3 ☐ Widowed 4 🛣 Div		1 Yes 2 II If Yes, Give Year or Dates:	Vo	1	☐ Yes 21 No	Specify:				Specify: Wh	nite	
2	72 hc 'natuı dica	eted	15. De (Specify only	ecedent's Edu highest grad	ucation de completed)		16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most	of workin	g	16b.	Kind of Business/	Industry	
7	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	ŝ+)		00 NOT use retired Lion Dire				Si.	dwall Fri	ends School	
7	2 should be filed with and Mental Hygiene. is marked other thar aumatic event, the N		17. Father's Name (First, M	Middle, Last)	4		Aucı	.ION DITE		's Name	(First, Middle	1	len Surname)	Tenas benedi	
0	ld be ental ked o	To Be	J. Albert Po		n				Edit	th A	lvinia	Li	ndroth		
2	should be ind Mental marked o	ř	19a. Informant's Name/Re	-			19b. Mailin	g Address (Street	and Number	r or Rura	Route Num	ber, Cit	y or Town, State, 2	Zip Code)	
Š	and 2 ealth a n 27 is ser trau		Edith Furber	Zhang	/ Daughte	r	5106	Newport	Ave. I	Beth	esda,	Md.	20816		
ני כ	of He of He rothe		20a. Method of Disposition		_		ace of Dispos	sition (Name of natory or other place	ce) M		ate 16,	20c.	Location - City or	Town, State	
	Pages ment of I ant: If ite ury or of		1 ☐ Burial 2 🖾 Crem 4 ☐ Donation 5 🗆 O			Met		Ltan Crem	atory	2	8000			, Virginia	
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Signature of Forneral S	Service Lizens	8 / //	-··		Name and Addre					1 Home ash.D.C.	20007	
7	4		23a. Part1. Enter the dise shock, or heart failur	ase, or comp	lications that caused	the death								Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	e. List only o				omyositis						Onset and Death	
	/Medical		resulting in death)		Due to (or as			DINYUSICIS							
	Examiner		Sequentially list conditions		b										
200	p #	Examiner	Sequentially list conditions if any, leading to immediate Cause (Disease or injury	te 2	Due to (or as	a consequ	ence of):								
_	and I-tran	хап	that initiated events resulting in death) Last		c Due to (or as	a consequ	ence of):				-				
00100	ficate be executed physician and s the burial-transit	alE		- U	м.		,								
000	ficate physis the	edical			.d										
. 504	The law requires that the death certifiate has been signed by the attending page 2 should be detached for use a	sician/M	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 □ Yes 2 ☑ No	anı	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у				23d. Date of de Month	livery Day Year	
)	at the by th tache	5	9 Unknown		9□Unknown							· ·			
Š,	w requires that the de been signed by the s should be detached	d by P	Part II. Other significant of	conditions of	ontributing to death b	out not resu	ılting in the ur	nderlying cause giv	en in Part I.		1			o the cause of death?	
3	w red s beer shou	Completed									24a. Wa	ıs an	24b. Were a	utopsy findings available	
ב	sician: The law certificate has t irector, page 2 s	dwo			.						aut per 1⊟ Yes	opsy formed 2 🔀	? death?	completion of cause of	
g	lan: 'rtifica'	Be C	25. Was case referred to I	medical					26. Place	of Death	(Check only		(NO) TETES	2 2 140	
>	nystc nis ce direc	To B	examiner? 1 ☐ Yes 2K No		Hospital: 1 ☐ Inpati	ent 2 □ I	ER/Outpatien	nt 3□ DOA Oth	ter: 4 ☐ Nur	rsing Hor	ne 5□Re	sidence	e 6 XOther (Spe	ecify) Hospice	
=	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐	Pending	28a. Date of Inju (Month, Da	ary ay Year)	28b. Time of Injury	Wo	rƙ?		28d. Describe	e how i	njury occurred		
2	Attending Physician: The sir death. rector: After this certificate hiby the funeral director, page	cati	2 ☐ Accident	investigation Could not be		At he	form ote		Yes 2□N		205 Leostian	/Ctuno	tond Number of D	wel Davida Number	
5	l or At after c Direc	Certification:	4 Homicide	determined	building, e	tc. (Specify	me, iarm, sir /)	eet, factory, office		4	City or T	own, S	tate)	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C			yslcian: To the best	of examinat									
	o the	Mec	29b. Signature and title of	certifier	and manner st			29c. Licens	se number			29d.	Date signed (Mon	th, Day, Year)	
l	F \$ F 0		1 Trens	oro 1	Ino all	0-	1	D00	064615				March 15	, 2008	
	1)		30. Name and address of	person who	completed cause of	death (Item	23a) (Type.	Print)							
			Genevieve		wski, M.D	. 135	55 Pic		Rockv	i11e	, Md.	208	352		
	Sta Registr		31. Date filed (Month, Day		204Degist	ror'o Ciano									
	3.0.		1111111	- 0 -0			No. Por	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Mary Ruth Furr March 16, 23:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🕅 F 83 536-28-8254 Director June 14,1924 California Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland | St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26426 Peninsular Drive 20636 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Specify: White 3€Widowed 4 □ Divorced 'natural", Be Completed and Mental Hygiene.

is marked other than "naturaumatic event, the Medical is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Chris Phillips Myrtle Josephine Spratling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26426 Peninsular Dr. Hollywood, MD 20636 Wendy Flynn / Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐Removal from State Metropolitan Crematory 03/18/2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Thechael P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LTSpirator **Physician** 10 days /Medical Tue to (or as a consequence of): Examiner Meumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of be executed burial-transi Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year i signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Henknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide

P.O. Box 68760 Division or Vital Records,

Maryland 21215-0036

Baltimore.

the Hospital or Attending

within 24 hours after death.

To the Funeral Director: Aft

State

4 Homicide

(Check only one)

29a, Certifier

Medical

determined

and manner stated.

29c. License number 1)25230

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 3-17-2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25500 Pointlookout Road, Leonardtown, MD 20650 David Allen, MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registra Signature 8 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month March 17, 2008 **Physician** George Alvin Grover 4:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hermitage at St. Johns Creek Solomons Calvert. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F 06/05/1906 216-18-5705 101 Yrs Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits rotified at 1 Yes 2 No Director MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or United States 13325 Dowell Road 20688 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify White 3 Widowed 4 □ Divorced Year or Dates: er than "natur, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer / Oysterman Farming / Waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked George R. Grover Ida P. Monnett ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth G. Dixon / Niece 920 Ed Joy Road, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) St. Paul U.M.C. Cemetery 03/22/2008 Lusby, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the diseal e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive heart 3 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has trector, page 2 s perform 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Avatural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in my opinion death accurred at the cause(s) and manner as stated 29a. Certifier Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5156 March 17, 2008 Benne (MA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Bennett, MD 11845 H. G. Trueman Road, Lusby, Maryland 20657

32. Registrary Signature 31. Date filed (Month, Day, Year) State MAR 1 9 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 13, 2008 Fredrick Eller Gardner 08:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13290 St. Johns Creek Road Calvert Lusby If Under 1 Year | If Under 24 Hrs. Social Security Number
 577–10–1976 6. Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 17, 1916 **91** Months Days Hours 1 **⊠** M 2 □ F Washington, D.C. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Maryland Calvert Lusby 1 ☐ Yes 2 🗷 No Director 0e. Street and Number 13290 St. Johns Creek Road 10f. Zip Code 20657 10g. Citizen of What Country?
United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Carpenter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredrick JOseph Gardner Lillie Eller P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13290 St. Johns Creek Road, Lusby MD 20657 19a. Informant's Name/Relationship (Type. Print) Margaret S. Gardner-wife other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Metropolitan Crenatory 03/15/2008 permit. Page Department of Important: If any injury or Alexandria, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertension Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Arthritis physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown nis certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 1 | Yes 2 | XNo 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 2 29c. License number D0052242 29d. Date signed (Month, Day, Year) 03/13/08 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. John Barth, III, M.D. 110 Hospital Rd. Prince Frederick, MD 20678 YRW. 31. Date filed (Month, Day, Year) 32. Registra Signature State MAR 18 2008 Registrar

	Phy /M Exa	sic ledi amii
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	the this certificate has been signed by the attending physician and

		Please	e Type or Prir							gible.	
	,	For	State of Ma	arylan	•	artment of H		lental Hyg	jiene		
		1 - State Registrar	L A)		Ce	rtificate of L	<i>Death</i>	2. Date of Dea	eg. No	08	10511
Physici	an	1. Decedent's Name (First, Middle, I						Month Day Year 7			7:15 p M
/Medic Examin		Mary Virginia I 4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Death	March		008 nty of Deatl	
Examin	ier	Homewood Nursin				Willia				ingto	
Funeral			. Sex 7. Ag	e (In yrs.	last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1	9. Birth	hplace (State or Foreign untry)
Director		215-14-1434	1□M 2X0F	85	Yrs.	Monato Bays	Tiodio Iviii.	March 4			land
and sw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
Mary -f sho	to	Maryland Washin	naton		Насо	rstown					1X Yes 2 No
after death with the Maryland or items 23a or 28a-f show miner must be notified at	Director	10e. Street and Number	igcon		nage	10f. Zip Code		1	10g. Citizen	of What Co	untry?
th wit 23a c		421 E. Washingto	on Street			217	40		USA		
r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame	rican Indian, e, etc.
s afte ", or i'	by Fi	1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 X I If Yes, Give Year or Dates:	No		1 □ Yes 🏋 No	Specify:	Spe			
thour patural		15. Decedent's			16a. Dece	edent's Usual Occupa	ation		16b. Kind of		White
hin 72 8. In "na Medic	Completed	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4or 5	·+)	(Giv	e kind of work done o DO NOT use retired	during most of work ()	king			,
d with	E I	9	0		Metal	former a	nd finish	ner	airc	raft	
be filk tal Hy d oth	Be	17. Father's Name (First, Middle, La	ist)				18. Mother's Nam	e (First, Middle,	Maiden Surr	name)	
ould Men narke	ဥ	Charles P. Fouke		T		Mae B.					
d 2 should be filed within 72 hours after death with the Manylan th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	15	19a. Informant's Name/Relationship	,,,		1	ing Address (Street a					
Heali Heali tem 2		Nevin Fouke - Bi 20a. Method of Disposition	rother	20b. F	Place of Disc	N. Canno	i	<u>Hagers</u>	town, 20c. Locatio		
permit. Pages 1 and 2.3 Department of Health at Important: If item 27 is any injury or other trau		1 M Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		}	•	ematory or other plac	i i	/00		,	
mit. for		21. Signature of Funeral Service Lic		KO		1 Cemeter 22. Name and Addres	<u> </u>	Minnich			Maryland
Ped in the		Scott	monas	me	4	15 E. Wil	son Blvd.				
5		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omp ications that caused ly one cause on each li	the deat	h. Do note	nter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	LUSTA	-11	Un 1) IFFICCE	CENT	Chacac	cal		Coset and Death
/Medical Examiner		resulting in death)	Due to (or as								0,7,5
	<u>-</u>	Sequentially list conditions,	b. Uue to (or as	a marcan	ane area of						
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be executed cian and purial-transit	Exa	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):						
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ertifica ing ph e as th	Physician/Medica	IF FEMALE:						- 1112	1		
death certifica attending ph	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Feta	al death 3	□Ectopic pregnancy	,		23d.	Date of del Month	ivery Day Year
he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at 9⊟Unknown	time of o	death 5	Other (specify)				MOTH	Day Tour
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the t	, Ph	Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
quires n sign ald be	d by	DIABETES ME	sectors,	140	E21	(HAUM C		1 🗆 Y	es 21 N	o 3 □ Pr	robably 4
s bee	lete	AMICAL FIRM	ACCCATTON	رار				24a. Was a	an 24	lb. Were au	utopsy findings available
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rsician: The law s certificate has t lirector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place of Dea		_ ~	1 163	2 110
hyslo	To	1 Tes 2 No	Hospital: 1 Inpatie		ER/Outpatie		4 Nursing H	ome 5 Resid	lence 6 🗆	Other (Spe	cify)
Ilng F After unera	iuo.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry <i>y Year)</i>	28b. Time Injury	Worl		28d. Describe h	ow injury oc	curred	
death ctor: / the	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 28a Place of init	urv - At he	ome farm s	M 1 □	Yes 2 □No	28f. Location (S	Straat and No	imbar or Pi	ural Route Number,
after after Dire	Certification:	4 ☐ Homicide determine	building, et			iroot, rabiory, ornoe		City or Tow	n, State)	iniber or ne	arar noute rumber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the best	of my kno	owledge, dea	ath occurred at the tir	ne, date and place	, and due to the	cause(s) and	I manner as	s stated.
the Hi in 24 the Fi	edical	(Check only 2 Medical Ex	caminer: On the basis o	f examina	ation and/or i	nvestigation, in my o	pinion, death occu	rred at the time,	date and pla	ce, and due	e to the cause(s)
Veith Com	Σ	29b. Signature and title of configer	1,	/	X	29c. Licenso	e number		29d. Date sig	ned (Mont	th, Day, Year)
1		- Wem	MEDIC	m/	INCO	74 1)	1/06)	MAN	CH W	12007
H-10		30 Name and address of person wi	no completed cause of d	eath (Iten	n 23a) (Type	Print Do ALK	- Hope	164000	1/11	1 51	747
Sta	te	31. Date filed (Many Day, Year)	32. gistr	ar's Signa	/SYZ	4 Idillo	HOE	STOREN	, me	0 21	146
Registr		mak 2 1	ZUUS	16735°	A A						

08-02049 Adapha Chiny	ere H		pe or Print i tate of Maryla							egible.			
		1- For State Registrar			tificate of			,		Reg. No.	20	108	1051
Physi Medical Exa		1. Decedent's Name (First, Midd						2	2. Date of De Month March 13	ath Day_	Year	3	Time of Death 0658 hrs
Medical Exal	mne	Adaoha Chin 4a. Facility Name (if not instituti		ilton	4	o. City, Town, c	or Location of		March 13		County of	Death	
		3575 Eastwest Highway Hyattsville Prince George											
Funer		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye			8. Date of E	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 1/13 c.h.			
Directo	or	217-19-1155	1 M 2 X F	27	Yrs.	Months Da	ys Hours	Min.	Augus	t 25,		Coun	wash. DC
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	n						1	0d. Inside City Limits
\$	g _	MD. Princ	ce George'	e Hys	attsvill	ام							X Yes 2 No
daryla 28a-f	Director	10e. Street and Number	000180		L C C D V I I	10f. Zip Code				10g. Citizen of What Cou			/?
h the M		6506 America		501		20782					JSA		_
r death with the Maryland or items 23a or 28a-f show	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was De	cedent Ever in U.S Forces?		 Was Decedent of Hispanic Drigin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 					14. Race White,		n Indian, Black,
Rer de:		3 Widowed 4 Di	1 Yes	2 X No	1	Yes 2X N	o specify:			5	Specify:		içan rican
ours al	yd b		or Dates: ecify only highest gra	ade completed)	16a. Decedent		ation (Give	kind of wo		16b. Ki	nd of Busi		
36 n 72 h	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)	•			use reure	su)				
215-0036 be filed within 7 nal Hygiene.	E O	17. Father's Name (First, Middle	5+1	-	Real I	state		's Name (First, Middle		Real]	Esta	te
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	Be C		,						l Park		,		
21, hould bend Men	2	19a. Informant's Name/Relation			1	Address (Stre	eet and Num	nber or Ru	ural Route N	umber, Cit	y or Town,	State, Z	ip Code)
, MD and 2 sho ealth and		Cheryl Hamilt	on / Moth		11600 Place of Disposit	Legend		Dr.	Bowi	e, MD	ocation - C	0720	own State
altimore, mit. Pages I ar partment of Hee portant: If ite		1 X Burial 2 Cremation	n 3 Removal f	from State C	rematory or other	er place)	citiotory,					•	
I ltim iit. Pa artmen ortand	5	4 Donation 5 Other S 21. Signature of Funeral Service		Fo	rt Linc		ss of Facility)/2008		ntwoo		MD. e, Inc.
Den Den G		andre In	anson		740	0 Georg	gia Av	ve.,	NW W	unera ashin	gton	, DC	e, inc. 20012
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	ie.	if any, leading to immediate cause. Enter Underlying Cause		a consequence of):								
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cords, P.O. law requires that the has been signed by	ğ g		·		·	, ,	•		1 🗆 Y	'es 2 🗸	No 3	Proba	bly 4 Unknown
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eco he law	E E			•					per	formed?	de	ath? ✓ Yes	2 No
al R ian: T	BeC	25. Was case referred to medica examiner?				26.Pla	ce of Death	(Check or					
FVit	10	1 ✓ Yes 2 No	Hospital: 1		ER/Outpatient		Other ₄		Home 5		nce 6 🗸		Scene
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Iteratural Director: After this certificate has been signed by the attending physician and more relatively and the control of the transfer of	Certification:	27. Manner of Death 1 Natural 5 Pen	dina FOUNT	h, Day,Year)	28b. Time of In	jury 28c. ln	jury at Work Yes 2 ✔	. 19	28d. Describ Subject cu				rom building
/iSic	ficat		estigation Mar 13 28e. Place	, 2008 ce of Injury - At ho	0650 hrs me, farm, street	, factory, office	building, et	tc. 2					Route Number, City
Div	ë		and a district of	Parking Lot				3	or Town, 575 Eastw	, State) est Highv	way , Hya	ttsville	, MD
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	cal	(3)	hysician: To the be										
To the within 2 To the	Medical	one) 2 ✓ Medical Example 29b. Signature and little of pertific	, and manner		id/or investigation		nse number	curred at	the time, da				h, Day, Year)
-5		255. Signature and interior definit	1				.M.E.				ch 14, 2		i, Day, i carj
DCME											, _		
		30. Name and address of person	who completed car	use of death (Item:	23a)								
		30. Name and address of person Mary G. Ripple MD.	Deputy Chief	,	niner 111	Penn Stree	et, Baltim	pre, Mi	O 21201			_	

			For State Registrar	Otate of Mary		rtificate of			Reg. No	008	10513		
	Physici		Decedent's Name (First, Middle, Last JEANNA MAR	•				2. Date of Demonth MARCH		2008	3. Time of Death 4:45P M		
	/Medio		4a. Facility Name (If not institution, give Casey House	street and number)		4b. City, Town, or Rock	Location of Dea		M	unty of Death	IERY		
	Funeral Director		Z1Z-64-1560		yrs. last birthday, 6 Yrs.	Months Days	If Under 24 Hr Hours Mir		, ^{Yea} 96	9. Birthpl Count Ma	ace (State or Foreign fry) ryland		
	a-f show	ctor	Usual Residence of Decedent		. City, Town or L	ocation aithersk	ourg			10d. Inside City Limits 1 🗗 e 2 □ No			
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 15 Goodport	Court		10f. Zip Code	877			of What Coun U.S.A.			
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status ↑★ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No lf Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XNo	ispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e pecify: Bla	etc.		
21215-0036	l within 72 ha liene. r than "natu the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th	lucation de completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retired Baker	ation during most of w i)	rorking		of Business/Inc akery	lustry		
yiand	uuld be filed Mental Hyg arked other atic event, i	To Be C	17. Father's Name (First, Middle, Last) William T. H					ame (First, Middle,		· ·			
s, Mar	and 2 sho fealth and I m 27 is ma her traums		19a. Informant's Name/Relationship (Frances Hall (Mother)	176	ing Address (Street	/ Dr.,	Gaither	rsbur	g, MD	20877		
saitimore,	nit. Pages 1 artment of H ortant: If Ite Injury or ot		20a. Method of Disposition 1 Surject 2 □ Cremation 3 □ 4 □ Departion 5 □ Other (Specification 2). Signification 5 □ Other (Specification 3).	A A	sh Mem	osition (Name of ematory or other place orial Ce 22. Name and Addre	em [3/]	L8/08	Sand		.ng, MD ME, P.A.		
eg D	Depa Impo any l		Though In	groude	yr.	246 N. V	Vashing	gton St	, Rock		MD 20850 Approximate		
	Physician /Medical Examiner		23a. Part1. Entey he diseased or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of):										
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200	w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month									
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N N	Physician: The this certificate ral director, pag	o Be (25. Was case referred to medical examiner?	Hospital:	00000	unt 3 DOA Oth		eath (Check only					
	ng ffer iner		1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time Injury	of 28c. Inju	4 🗆 Nursing	28d. Describe			W Hospice		
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Sp	pecify)			City or To	wn, State)		I Route Number,		
	thin 24 hou thin 24 hou the Fune mpletely fin	Medical	(Check only 2 Medical Exar	ysician: To the best of my niner: On the basis of exa and manner stated.			opinion, death o		, date and pl	lace, and due to	o the cause(s)		
1	3	=	29b. Signature and title of certifier	molelans	s m		D06461	4		3 2/08			
2,	Ct.	to-	30. Name and address of person who Genevieve Wr 31. Date filed (Month, Day, Year)		M.D. 6		caster	Mill Ro	d, Ro	ckvil	20850 Le,MD		
	Sta Registi		MAR 1 8 20			estel.					·		

DHMH 17 Rev 1/2001

Amend Items 27,28a-f per me 8878.04/03/08dhb

For Amend Item 8 23 state of Maryland / Department of Health and Mental Hygiene
State Registrar WCHD/SH 3/24/08 per FH Certificate of Death

Reg. No. 2000 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** Month Martha Wilma JACKSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 8. Date of Birth 7/2/1/1 92 (Birthplace (State or Foreign (Month, Day, 7/4a)) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 1 ☐ M 27 F Director 235-34-4824 June 21 1920 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d Inside City Limits ns 23a or 28a-f shov must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Items 23a 9751 Beaver Creek Church Road 21740 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 9 altimore. Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: "natural" White er than "natura the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector Rubber Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles A. Deems Zona Susan Rains Health and I tem 27 Is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Jackson - Husband 9751 Beaver Creek Church Road, Hagerstown, Md.21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any Injury or o Department of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Rose Hill Cemetery 3/24/08 Hagerstown, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not affect the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. E. Wilson Blvd. Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death ripple In TITUS Immediate Cause (Final **Physician** ardiopulmonary asses ATION APPROVED BY MEDICAL EXAMINER resulting in death) /Medical Due to (or as a consequence of) Examiner Skoke Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine CERTIFY use as the burial-tran Due to (or as a Box 68760 physiciar death certificate be Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 No 4□Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, page 2 should be Isr later 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation **Unknown**M 11/29/2007 To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Tes 2X No Subject fell death. 2 XAccident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9751 Beaver Creek determined 4 ☐ Homicide Home Church Rd. Hagerstown MD 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 44996 19, 2008 person who completed ed cause of death (Item 23a) (Type, Print)

MD 20 311 Lappans Doansboro MD 21713 V9H-3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

DHMH T/ Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Dwayne Damon Kelly Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2020 hrs **Medical Examiner** Kelly March 14, 2008 Dwayne Damion 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) North East 304 Baron Road g. Birthplece (State or ton If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** chamaica Months Days Hours Director 23 9-18-1984 1 XM 221-96-0314 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State X Yes 2 No 23a or 28a-f show notified at once, NewCastle NewCastle DE hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19720 USA Independence Blvd. 107 E. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes _{Specify:}Jamacian f Yes Give Yea Yes 2 X No specify: 3 Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 72 other than the Medical Baltimore, MD 21215-0036 ges I and 2 should be filed within of Health and Mental Hygiene.

If item 27 is marked other that lawncare 12 laborer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Pryce Be Desmond Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 🔒 19a. Informant's Name/Relationship (Type, Print) 107 E. Independence Blvd.NewCastle,DE Ruby Pryce Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 3/22/08 NewCastle, DE Gracelawn Mem.Park tant Donation 5 Other Specify 21. Signature of Fundal The House of Pacility 208 E. 35th S Wright Mortuary Street Wilm.,DE 19802 23a. Part / Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has b ector, page 2 sh performed? death? 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Mar 14, 2008 Subject shot 1958 hrs Natural 1 Yes 2 ✔ No Director: Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 304 Baron Road , North East, MD determined 4 V Homicide (Specify) Residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. March 15, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. istrar's Signature 2008 State 1^{ar})9 Registrar

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To the Hospital o within 24 hours aft To the Funeral DI

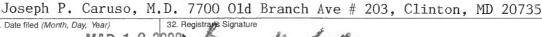
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Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

deren pl

and manner stated.



29c. License number

MDUU/5013

29d. Date signed (Month, Day, Year) 3/17/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Donald Louis Lyons 18 2008 12:25 P M 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/16/1944 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 ☐XM 2 ☐ F 219-42-8873 63 DE Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10240 Golf Course Rd. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Public Works Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zane Gray Lyons Agnes Elishia Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10240 Golf Course Rd., Ocean City, MD 21842 Beverly A. Lyons / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/19/2008 Frankford, DE 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 21. Signature of Fugeral Sonice Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown wificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? I Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Department of Important: If eny injury or page.

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the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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The law requires that the death certificate be executed ettending physicien end for use as the burial-transit signed by the e peen s page 2 s has Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,

Completed by Physician/Medical

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Certification:

Medical

2: a Certifier

(Check only one)

30 Name and address of person

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical

24a. Was an	24b. \
autopsy performed2*	
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examiner?	o to medical		26. Place of Death (Check only one)										
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 Magner of Death Natural Accident 	5 Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury a Work? 1 ☐ Ye		28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286.	Place of Injury - At building, etc. (Spec	home, farm, stree	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					

2 Accident	investigation		IVI	1 1 1 1 1 1 1 1 1	2 🗆 140
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, factory)	ory, office	

Certifying Physician: To the best of my knowledge, death cooursed at the time, date and place, and due to the causa(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) in my opinion, death occurred at the time, date and place, and due to the cause(s) in my opinion.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State Registrar

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State Registrar mobil Negi

31. Date filed (Month, Day, Year)

Veterans Huy

32. Registra Signature

millersville, pr 21102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAR 1 4 2008 >

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours a 24

within 24 State Registrar

KOTEV 31. Date filed (Month, Day, Year) MAR 1 4 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Regetrar's Signature

600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287

29c. License number

29d. Date signed (Month, Day, Year)

RES-000 MARCH 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#31 per AACO State of Maryland / Department of Health and Mental Hygiene Registrar 3/14/08 CMH

Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:23 PM Thomas Edward Myers 2008 11, March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center <u>Glen Burnie</u> 8. Date of Birth (Month, Day, Year) June 9 194 Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F 66 Ohio 268-36-5472 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked oth than "natural", or Items 23a or 28a-f show any Injury or other traumante event, the Medical Examiner must be notified at Severna Park 1 ☐ Yes 2 🙀 No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 466 Retford Drive 21146 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Project Planner Northrop Grumman 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Myers Ruth Wood 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 Carolyn Kay Myers/Wife 466 Retford Drive March 15, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Annapolis, Maryland Hillcrest Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Mony/ 23a. Parfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician andrac disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit that the deeth certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the a □Yes 2 No P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2XNo Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient ျ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 1 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1509 Ritchie Hwy, Amold, MD 21012

State of Maryland	Department of Health	and Mental Hygiene

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н	Physici /Medi		Robert Paul	McDevitt					Month March	16, 20	Year 08	2:15p M			
	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, T	Town, or L	ocation of Death		4c. Coun	ity of Death	1			
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1		1 □ Vac 2		oanic Origin? (Sp , Mexican, Puerto Specify:	Rican, etc.)		lack, White, o	etc.			
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Baltimore,	ages 1 au int of Hea t; If Item / or othe		20a. Method of Disposition 11 Burial 2 □ Cremation 3		20b. Place of cemeter	Disposition (Name y, crematory or oth Heaven	e of her place)	Mar terv	Date Ch 19,	20c. Location	n - City or To	own, State			
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	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
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<u>></u>	Physician: this certificatel director,	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐Mnpatient	2 ER/Out	tpatient 3 DOA	Other:	4 ☐ Nursing Ho	me 5 ☐ Resid	dence 6 🗆 C	Other (Specifi	y)			
ion	Attending P r death. ector: After t by the funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat			ime of 28 njury M	3c. Injury a Work? 1 ☐ Ye	at es 2 □ No	28d. Describe I	now injury occ	urred				
Division	al or Attendates after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ed 28e. Place of injury building, etc.		rm, street, factory,	office		28f. Location (5 City or Tox	Street and Nur vn, State)	nber or Rura	al Route Number,			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of e and manner state	xamination and	, death occurred a d/or investigation,	at the time in my opii	, date and place, nion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as st e, and due to	lated. the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/		29c.	License r	number		29d. Date sig	ned (Month,	Day, Year)			
	1.1		Barbara	Suparich,	Rem	MD		D65485		3/1	7/20	908			
	#DT1		30. Name and address of person who Barbara Supanic	no completed cause of dea	th (Item 23a) (Type, Print) st Glen	Road	, Silver	Spring						
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 8 200	32. Registrar	-	carti p									

DHMH 17 Rev 1/2001

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		For State Registrar	State	of Maryl		epartmer C <i>ertifica</i> :			ana iv	ientai Hy	/giene Reg. No.	200	R	105	22
Physicia	an	1. Decedent's Name (First, Middle			-					2. Date of D	eath	Ye	ar	3. Time of D	-
/Medic	al		012	d a complete of		4h Cih.	Town	Leading	of Dooth	3	13	County of E	3	1813	ęм
Examin	er	4a. Facility Name (If not institution WWWYSTY DEMO		A	Center	c mul	, rown, or LHM B	Location	or Death		46. (County of E	Jealn		
Funeral		5. Social Security Number	6. Sex 1 M M 2□	7. Age (In)	yrs. last birth	day) If Unde	r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of B	irth lav, Year)	9.	Birthplac	ce (State or I	Foreign
Director		213-22-7405 Usual Residence of Decedent	1 X M 2 L	F 81	Yı	rs.				1/17/	L927		Mary.	land	
yland now at		10a. State 10b. County		10c.	City, Town								10d	. Inside City	
e Mar 8a-f sl	Director	Delaware Suss	sex		Seafo									1 □ Yes 2	2 Mo
a or 2	Dire	10e. Street and Number	D.				p Code					en of Wha	t Country	1?	
death ms 23	Completed by Funeral	29500 N. Oak (12. Was	Decedent Ever i	n U.S.	13. Was Dece	9940 edent of Hi	ispanic Or	igin? (Sp	ecify Yes or N	US	4. Race - /			
or ite		1 Never Married 2 Marr	ied 1 XX	d Forces? ′es 2 ☐ No s, Give Army or Dates:Army	7	1 ☐ Yes		Specify:		Hican, etc.)		Black, V Specify:	White, etc		
hours tural"		3 ☐ Widowed 4 ☐ Divorced		or Dates: • • • • • • • • • • • • • • • • • • •	1	Decedent's Usi		ation				d of Busin	whi ess/Indu		
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ed wit	Com	7	_	•	la	athe op	erato			/80° 4 8 8 4 4			Indu	stries	3
d be fil	Be C	17. Father's Name (First, Middle, Jerome S. Moon								e (First, Middl Timmon:		Surname)			
shoul and Me s mark umati	٢	19a. Informant's Name/Relations	hip (Type. Print))	19b. i	Mailing Addres	ss (Street a	and Numb	er or Rur	al Route Num	ber, City or	Town, Sta	ite, Zip C	'ode)	
and 2 ealth a m 27 ls		Mary Louise Mo	ore/wif			29500 N		c Gro			-				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 → Burial 2 ☐ Cremation		rom State	cemetery	Disposition (Na , crematory or	other plac		3/19	Date	İ	cation - Cit	-		
nit. Pa artmer ortant injury		4 □ Donation 5 □ Other (S	//		Jer usa	lem Cer	and Addres	ss of Facili	ity		1	sonsk			
Depa Impo any i		to the k	face	1		Holl 501	oway Snow	Fune Hill	ral Rd.	Home Pr	rofes: sbury	siona , MD	l As 2180	sociat 4	tion
4.		23 Part1 Enter the disease, or shock, or heart failure. List	complications to only one cause	t caus the c	death. Do no	ot enter the mo	ode of dyin	ig, such as	carriac	or respiratory	arrest,		- 1	Approximate nterval Betwonset and De	/een
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Anoxic I	7 100 01	B					11060				
Examiner				e to (or as a con	TIM K	West		~ 1	- 1	MEDICAL	XXM				
D #	iner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last													
executed in and ial-transit	xamine														
	cal E		d				CA								
ing phy	Medi	IF FEMALE:						1							
leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 DL	s, outcome pf pre live birth 2 □ I Pregnant at time	Fetal death	3□Ectopic 5□ Other (s		/			2	3d. Date of Month			ear
the de	Physician/Medical	1 Yes 2 No 9 U⊓known		Jnknown	ordeatti	5 Other (s	specify)				month out				
The law requires that the death certificate be ate has been signed by the attending physicis bage 2 should be detached for use as the bur	by P	Part II. Other significant conditi	ons contributing	to death but not	resulting in	the underlying	cause giv	en in Part	l.					cause of de	/
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	Be Co	25. Was case referred to medica	ı					26. Plac	e of Deat	1□ Yes		1 1 L	Yes 2	!□No	
hysic his ce	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:		2 ER/Outp	patient 3 🗆 🗅		4 🗆 19	ursing H	ome 5□Re	sidence (6 □Other	(Specify)		
ding P		27. Manner of Death 1 Natural 5 Pendir investi	ig - f	Date of Injury Month, Day Yea		me of jury) NK M	28c. Injur Wor	yat k? Yes 2. ∑	(No	28d. Describ	e how injur	y occurred	oil		
Atten r death ector: by the	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. F	3 / 2009	At home, farr			100 214	1110	28f. Location	Street and	d Number	or Rural	Route Numb	ber,
Ital or rs afte rai Dir	Cert	4 Hornicide		ouilding, etc. (Sp	me					29500	NOTT	_	Gro	Fordi D	12Lewore
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical		Examiner: On t	o the best of my the basis of exar manner stated.)
To the vithin somple	Med	29b. Signature and title of certifie		mariner stated.		2	9c. Licens	e number			29d. Dat	e signed (Month, D	ay, Year)	
XIX		rust	ND	follow pr	Ш87И	an	187	131			3/12	108	194	Opm	
(2) EN		30. Name and address of person	who completed				120 n 1 -	101:	. 1 4	2100	,				
Sta	te	31. Date filed (Month, Day, Year,		32 Registrar's S	N COVU Signature	-84.	rruurl	MOTO	(W)	, 400	1				
Registr		MAR 1 9	2008	Dev	St.	God L	1								
MH 17 Rev 1/26	001				4	7									

State of Maryland / Department of Health and Mental Hygiene, 1 - State AMEND#16a&b, perINF, 3/20/08, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DENNIS JOSEPH REILLY, JR MAR 15 2008 12:15 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Yrs 87 577-14-1015 Director May 18, 1920 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

The state of the state of the stan "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20814 United States 4605 West Virginia Funeral Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1937-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced 1962 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Chief Aviation Machinist Mate 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy U.S. Military Officer Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis J. Reilly Sr. ည Christine McArtor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Reilly / Wife 4605 West Virginia Avenue, Bethesda, MD 20814 20b. Place of Disposition (Name of competery, crematory or other place)
Arlington National
Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State Department o Important: If any injury or once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March 27 2008 4 ☐ Donation 5 ☐ Other (Specify) Arlington , Virginia 21. Signature of Funeral Sen 22. Name and Address of Facility DeVol Funeral Home 19 East Deer Park Drive Gaithersburg, MD 20879 TRACY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOGENIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NON-ISCHEMIC CARDIOMYOPATHY Physician/Medical Examiner Due to (or as a consequence or, Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes certificate 2∏ No 1□ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 Pending investigation (Month, Day Year) 1 X Natural Injury s after dea... 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier D-64164 NATIONAL NAVAL MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) ROBERT F. BROWNING LCDR MC USN BETHESDA MD 20889-5600

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygiene	.000 1002	Þ
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Las	ANN Rai	Vdolph	2. Date of Death Month Da	y Year 3. Time of Death 11,205 AN	А
	Examir Funeral Director	ner	215-16-3336	Harbor Roc	ad Pocomoke	rs. 8. Date of Birth	Vorcester	חק
	Marylend a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	ester Poc	Town or Location		10d. Inside City Limit:	
	eth with the s 23s or 28s	Funeral Director	10e. Street and Number	Harbor Ro	ad 21851		tizen of What Country?	
5-0036	72 hours after deeth with the Marylend natural', or Itams 23a or 28a-f show disal Examena me must be profilled at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
21215-0	within 72 ho lene. than "natur the Medical.	Completed	15. Decedent's Ec (Specify only highest gra		16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)		(ind of Business/Industry	
Maryland 2	should be filed with nd Mental Hygiene i marked other thai umatic event, the	To Be C	17. Father's Name (First, Middle, Last)	Lane	A	ame (First, Middle, Maider		
	es 1 and 2 of Health a fitem 27 is r other tre		19a. Informant's Name/Relationshil (1) EUW C Blake 20a. Method of Disposition 1 M Burial 2 Cremation 3 C	daughter 20b. Place	19b. Mailing Address (Street and Number or be of Disposition (Name of netery, crematory or other place)	or Road P	or Town, State, Zip Code) ocation - City or Town, State	150
Baltimore	permit. Pag Depertment important: I eny injury o once.		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funera) Service Licen	1000	J 22. Name and Address of Follity B	envie Smi- Pocomoke	more Md. th tungral Home	= 13
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or companded, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line. a. ALZHEIME Due to (or as a conseque)			Approximate Approximate Interval Between Onset and Death	
8760,	certificate be executed thing physicien and tse as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. First Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.				
O. Box 6	certific Iding p	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ Vo 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal d} \) 4 \(\subseteq \text{Pregnant at time of dea} \) 9 \(\subseteq \text{Unknown} \)	eath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year	
α.	sign sign be	þ	Part II. Other significant conditions of	ontributing to death but not resulti	ing in the underlying cause given in Part I.		use contribute to the cause of death?	m
Il Records,	The ate h page	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 3 0	le
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othon	leath (Check only one)		=-,1
of	를 들 필	- To	1 Yes 2 No 27. Manner of Death	1 □ Inpatient 2 □ EF	-Voutpatient 3 DOA 4 Nursing	Home 5 Residence 28d. Describe how inju		_
Division	or Attending Phy uter death. Director: After thi in by the funeral	Certification;	1	(Month, Day Year)	Injury Work? M 1 Yes 2 No		and Number or Rural Route Number.	
Div	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the 1		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	edge, death occurred at the time, date and pla	City or Town, Stat	re)	
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical			n and/or investigation, in my opinion, death oc			
	To the compo	Me	29b. Signature and title of pertiner	nd MD	29c. License number		ate signed (Month, Day, Year) 3 118 (2008	
	70,		30. Name and address of person who s	completed cause of death (Item 2	(3a) (Type, Print) 1604 MARICET ST	POLIDMOKE	MD 21851.	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Rigistrar's Signatur				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Item 40	State of Maryland per dr.,g878	,04 <i>6</i> 01	rtment of F /08dhb iiicate of i	lealth and Death	Mental Hy	giene Reg. No. 20	08 10525
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	eath Day	3. Time of Death		
	/Medic	al	4a. Facility Name (If not institution, give s		r Location of Deat	3	4c. County of			
,	Funeral Director	er	University of they 5. Social Security Number 6. Se	und Hospita	1		If Under 24 Hrs Hours Min.	8. Date of Bit	th -	9. Birthplace (State or Foreign Country) York, PA
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Maryl a-f sho ffed a	tor	PA Yor	k S	Spring	Grove				1 □ Yes 2 No
	ith with the 23a or 28 ust be not	ral Director	10e. Street and Number 390 Little Creek	Rd.		10f. Zip Code	17362		10g. Citizen of Wh	nat Country? JSA
5-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in U.S Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	lf lf	/as Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. White
0-91212	□ · _ 60	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give k life. D	O NOT use retired	durina most of wo	_	16b. Kind of Bus Heavy (Machine	Construction
Maryland 2	uld be filed withi Vental Hygiene. Irked other than Itic event, the M	To Be C	17. Father's Name (First, Middle, Last) Fred C. Shaff	er				me (First, Middle Miller	, Maiden Surname)
, Mary	Pages 1 and 2 should be file tent of Health and Mental Hy, nt: If Item 27 Is marked othe ry or other traumatic event,		19a. Informant's Name/Relationship (Ty) David J. Shaf	fer, Son	6195	PaHaGaCo	Rd., SI		oer, City or Town, S OVE, PA	itate, Zip Code) 17362
altimore,	Pages 1 ment of He lant: if Iten jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place St.	Jacob		n Cem. 3,		York Nev	city or Town, State V Salem, PA
Rail	permit. Pag Department Important: i any Injury o		21. Signature of Funeral Solvice Licens	Munane					enstein M dom,PA	iortuary, Inc. 17349
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line. a. Due to (or as a consequ	Disc		ng, such as cardia	c or respiratory a	ırrest,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underson injury that initiated events resulting in death) Last	Due to (or as a consequ						
09/89	ficate be executed physician and the burial-transit	edical E		d	·					
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ras, F	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions cor	ntributing to death but not resu	lting in the und	derlying cause giv	en in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
vital Records,	The larate has	Completed						24a. Was auto perf 1∐ Yes	ppsy pr ormed? de	fere autopsy findings available for to completion of cause of eath? □Yes 2□ No
<u> </u>	Physician: this certific	o Be	25. Was case referred to medical examiner? 1 Tes 2 No	lospital: 1 Nanpatient 2 □ E	R/Outpatient	3□ DOA Oth	or-	ath (Check only		r (Snacify)
Vision or	nding Phys nth. r: After this e funeral dir	⊢	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	y at k? Yes 2 □ No		me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
DIVIS	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28f. Location City or To	ocation (Street and Number or Rural Route Number, City or Town, State)					
	ne Hospi n 24 hour ne Funer oletely fill.	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time	cause(s) and man , date and place, e	nner as stated. nd due to the cause(s)
	To th To th	M	29b. Signature and title of certifier	V M. D	,	29c. Licens	e number 1764 3 5	5518176		(Month, Day, Year)
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	rint)				
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2008	82. Registrar's Signat	ure	w	Ballillo			- 1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thelma Irene STROGISH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Loyalton Assisted Living Hagerstown Washington 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Davs 1 ☐ M 2 💢 F Director 82 26 1925 Pennsylvania 179-20-3631 Aug. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death v 11208-D Pepperbush Circle 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Funeral 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other them? any Injury or other traumore. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Mfg <u>Assembly</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ဂ Charles Edwin Reese Myrtle C. Faust 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Datum - Daughter 340 Nottingham Road, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dueen of Heaven Cem. 3/26/08 Pittsburg, Pa. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician carcinoma 0, Ovarian /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f a I Inknown 9 Unknown signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 00 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performer es 1⊟ Yes or Attending Physiclan: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Watural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

5H-1

State Registrar

(Check only

29b. Signature and title of certifier

St. Hagerstown 354

and manner stated.

30. Name and addless of person who completed cause of death (Item 23a) (Type

Monec

DHMH 17 Rev 1/2001

completely

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAR 1 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician March 14, 12:20 P M Primitiva Sabater 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 18408 Bright Plume Terrace Boyds Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. Days 1 □ M 21 F Hours Director 214-11-8599 Philippines Feb. 20, 1916 Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐Yes 21 No Director Maryland Montgomery Boyds 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 18408 Bright Plume Terrace Funeral 20841 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify 2 3 Widowed 4 □ Divorced Asian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) wental Hygiene. 127 Is marked other than "-r traumatic eve-" Elementary/Secondary (0-12) College (1-4or 5+) 4 Nurse Nursing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Santos 2 Roman Feliciana Esbiritu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18408 Bright Plume Terrace, Boyds, Maryland 20841 Bernadette Cordero/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 3/19/2008 | Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee LO East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Physician/Medical the S 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Q autopsy perform age te 1□ Yes 2X No this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 X Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending (Month, Day Year) 1 X Natural 5 Pending Injury after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a the Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. (Check only one)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Vinu Ganti, M.D., 31. Date filed (Month, Day, Year) MAR 18 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

NA

19529 Doctors Drive, Germantown, Maryland 20874 Registrar's Signature

Registrar

29c. License number

D 41162

29d. Date signed (Month, Day, Year)

March 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Year **Physician** ITUS 15 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 8. Date of Birth 9. Birthplace (State or Forei MARCH 21, 1927 NEW HAMPSHIRE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F 80 578-20-5293 Director Usual Residence of Decedent death with the Maryland 10a. StatWEST 10b. County 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 No VIRGINIA BERKELEY FALLING WATERS Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 218 AMHERST LANE 25419 UNITED STATES Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 X Yes 2 No If Yes, Give Year or Dates: 1945– Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1946 1 ☐ Yes 2 No Specify. WHITE Specify: à 3 ☐ Widowed 4 X Divorced "natural", Completed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICAL ENGINEER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RITA MAE CORWIN IRVING BUTTON TITUS 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 928 MONROE MANOR ROAD, STEVENSVILLE, MARYLAND 21666 JEFFREY PAUL TITUS/SON Health a other MARCH 21 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State FORT LINCOLN other place) Important: If It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 2008 BRENTWOOD, MARYLAND 4 □ Donation 5 □ Other (Specify) CEMETERY HELFENBEIN AND NEWNAM RE PA 814 BESTGATE D 21401'' 22. Name and Address of Facility FILLOWS . HI CREMATTON AND FUNERAL CARE ROAD , ANNAPOLIS , MARYLAND 21. Signature of Funeral Service Lipes Will Elso M00672 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final VA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Ran The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph d for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 2 30 certificate 1∐ Yes or Attending Physician: director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2 XNo P 1 npatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury M 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and title of certifie

Registrar

State

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31. Date filed (Month, Day,

Name and address of person who comp

Year)

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cause of death (Item 23a) (Type JA W 445 32. Pygistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Washington Orlando Taylor II Monet 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MICIMICO ENINSULA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Hours 213-22-7946 80 Director Maryland 8/3/1927 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medic I Examiner must be notified at 1 Yes 2 No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 406 Washington Street 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Co. cable splicer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford A. Taylor Sadie Holt 19a. Informant's Name/Relationship (Type. Print)
Jeanette Taylor/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Washington St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/20/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Funeral Service Licensee 2. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEOWIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 Other (specify) ed by the a detached t 9☐Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy perform certificate Division or Vital 1☐ Yes 2 No To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Mann f Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar

HIMMAR 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

Easken Shore Dr. Salisbury

08-00663 Gary A. Taylor **Funeral** Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1053 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Medical Examiner 2000 hrs Gary A. Taylor January 23, 2008 ic. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex If Under 1 Year | If Under 24Hrs. 7. Age (In yrs, last birthday) Months Days Hours Min 219-46-8843 Country Maryland 1 XM 2 F 08/26/1948 Yrs Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Somerset Deal Island be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24633 McInturff Road 21821 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes If Yes, Give Year Vietnam 3 Widowed 4 X Divorced Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Wallpaper Hanger permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the none Home Improvement 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Norman King Vera Watford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is m Pamela Myers/Daughter 9225 Megatha Lane, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 02/01/2008 Cheltenham Veterans Cheltenham, MD Donation 5 Other Specify 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licenses 11673 Somerset Ave., Princess Anne, MD 21853 James L. Hinman Jr. M00295 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Complications of pancreatic adenocarcinoma Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X AMENDED 1-4c per ME 5-22 per FH g878 4/1/08 amh UNPENDED attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be of Vital Hospital: 1 Inpatient Other-ER/Outpatient 3 Nursing Home 5 Residence 6 2 Other 1 V Yes the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Yea 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural within 24 hours after death. To the Funeral Director: 1 Yes 2 No Pending 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 _ Suicide Could not be determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Din whinits Down Ml O.C.M.E. January 24, 2008 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 0 Registra

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JOHN J. VINCENT 3/14/08 @ 0111 AM	Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed
-		

		1 - State Registrar				Ce	ertificate of	Death	Mental Hygiene Reg. No 2 0 0 8 1 0 5 3 2					
ysici	_	1. Decedent's Name (First, Middle, Last) John Joseph Vincent						2. Date of Dea Month March	3. Time of Death					
ledic amin	20.00	4h City Town or Location of Dooth								4c. County of Death				
allilli	lei	Suburban Hospital Bethesda								Montgomery				
eral	w*	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde						If Under 24 Hrs	8. Date of Birt	h	Birthplace (State or Foreign			
ctor		549-50- Usual Residence o		X □M 2□F	70	Yrs.	Months Days	Hours Min.	Jan. 8,	(Month, Day, Year) Jan. 8, 1938 Califo				
dat	<u>_</u>	10a. State 10b. County 10c. City, Town or Location						10d. Insid						
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	Maryland 10e. Street and Nu		Montgomery Si			lver Spring 10f. Zip Code			10g. Citizen of What Country?				
		11900 Charles Road					2090	06	USA	USA				
mus	era	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	. Was Decedent of H		Specify Yes or No-		ce - Americ			
niner n	Funeral	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes, Give			2√ 3€No	0	If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		to Rican, etc.)		Black, White, etc. Specify: White			
	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.C Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 Norma Joyce Wise 9:00 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 201 215-34-9648 69 Georgia May 25, 1938 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other tranualic event, the Medice Examiner must be notified at any Injury or other traumatic event, the Medice Examiner must be notified at 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Tennessee Hamilton Signal Mountain Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 180 Woodcliff Circle U.S.A. 37377 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claude Alexander Langston, Jr. Zaidee M. Pruitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracy Zhang/daughter 540 Hollyhill Drive Lexington, Kentucky 40503 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3/12/2008 Baltimore Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Year resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last ed by the attending physician and detached for use as the bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar was a... autopsy performe has 1 ☐ Yes 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 P/Outpatient 3 DOA 21 Y No 1 Inpatient P 1 Yes this s after death. 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

the Hospital or Attending Physician: 24 hours a the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Annegelis Mel 21401 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 31. Date filed (Month, Day, Year) MAR 14 State 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Howard J. Wright , Jr. 10, 2008 8:23 P M March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 1196 River Bay Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months **™** M 2□ F New York 055-34-4794 65 1943 Director Jan. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Annapolis 1 ☐ Yes 2 No MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21409 USA 1196 River Bay Road Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after comportant of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baking Companies Self Employed Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard J. Wright, Sr. Betty Fraizer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1196 River Bay Road Annapolis, MD 21409 Joan R. Wright/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 15, 1∑ Burial 2 ☐ Cremation 3 ☐Removal from State 5 ☐ Other (Specify) Elkridge, MD Meadowridge Memorial 2008 22. Name and Address of Facility Barranco & Sons, P.A. Funeral Service Ligenses 21. Signature o Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cavcinoma Immediate Cause (Final disease or condition resulting in death) **Physician** wo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 1 ☐ Yes 2 ☐ No 9∏Unknown 9 ☐Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 2**X** No 2 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? After (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Funeral Director completely filled i by the within 24 hours a To the Funeral C To the Hospital

State Registrar

of death (Item 23a) (Type, Print) 900 Bestgate Rd. Annapolis, und.

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 2:32 a M March 10, THOMAS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth (Month, Day, Sept. 21 Birthplace (State or Foreign Country)
 Germany Age (In yrs. last birthday) 1923 **Funeral 1** M 2 □ F 84 216-44-7629 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic at any injury or other traumatic at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2 No Severna Park MD Anne Arundel Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21146 34 Emerson Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW] 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2X Married White 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WW II 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 5+ Oceanographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsbeth Michael Henry Winterfeld 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, MD 21146 34 Emerson Road Sue T. Winterfeld/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 12, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Fineral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 non 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of) attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Minknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 (2/No certificate or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Cetter

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 4 2008

Berhane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore Washington Medical Center Glen Barnie, MD
32. Applistrar's Signature

DHMH 17 Rev 1/2001

SION

10055703

08-02336 David A Webb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici	ian/	Req 1. E	<u>istrar</u> Decedent's Name (First, Middle	,Last)								Date of Dea Month	Day	Year	3.	Time of Dea 1420 hrs	1	
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("		4a.	Facility Name (if not institution, give street and number)				46	b. City, Town, or Location of Death Salisbury					- 1	/icomic				
			Peninsula Regional Me	edical Center				If Under 1	<u> </u>	If Under	24Hrs.	8. Date of B	rth (MM/E	D/YYYY)	9. Birthp	lace (State o	or	
Funeral		5. \$	Social Security Number	6. Sex	7. Age (In yrs.	. last birth	iday)		Days	Hours	Min.	9/22/			Foreign Count		1	
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5-0036 led within 72 hours after death with the Maryland Hygiene. other than "matural", or items 23a or 28a-f sho	1	?⊢	5. Decedent's Education (Spe) 16a.	Deceden	t's Usual Oo ost of worki	ccupatio	on (Give k	ind of wo	ork done	16b. l	Kind of Bu	isiness/In	dustry	ł	
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Page nent c	or of	1	Donation 5 Other 5	Specify:		Cape	Hen	lopen	Address	of Facilit								
Baltimore, MC permit. Pages 1 and 2 s Department of Health a Important: If item 27	jury	2	1. Signature of F eral Service	e Licensee							ine	Burb	aye MD	218	11			
	_	4	22 Day 1 From a dispess	or complications tha	t caused the de	eath. Do r	not enter	the mode o	f dying,	such as	car lac o	r respiratory	arrest, s	hock, or h	eart		ate Interval Onset and	
Physicia Medic		1	23a. Part I. Enter le discusse on each lie. Immediate Cause (Final disease a. Aurootic (heroin) intoxication 108 William St Berlin. MD 21811 108 William St Berlin. MD 21811 Approximate Interval Between Onset and Death Death											eath				
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ospit bour	uners ty fill		4 Homicide 29a. Certifier (Check only) Certifyin	g Physician: Toth					he time,	date and	place, a	nd due to th	e cause(s) and ma	inner as s	tated. the cause(s	s)	
the II	the F	Medical	(Check only one) 2 ✓ Medical	Examiner: In the	sis of examin	ation and	or invest	igation, iii i	пу орпт	ion, doda		d at the time				Month, Day,	Year)	
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			30. Name and address of pe	rson who complete	d cause of deal	th (Item 2	3a)		D 111		D 240	_ _						
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Death

Year

2 No

or Town, State)

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29d. Date signed (Month, Day, Year)

March 25, 2008

the Hospital or Attending Physician: Division of Vital in 24 hour. the Funeral Dire

Medical within 24 To the F State Registrar

3

4

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

30. Name and address of person who completed dause of death (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year)
MAR 2 8 2008 32. Registrar's Signatu

Th

(Specify)

and manner stated

Could not be

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13, 2008 **Physician** рМ Alice C. Warren March 4:25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2280 Ingleside Court Waldorf Charles 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 ▼ F 82 217-28-8129 26, 1925 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County s 23a or 28a-f show rust be notified at show 1 ☐ Yes 2X No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 U.S.A. 2280 Ingleside Court ? Is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Her Home permit. Pages 1 and 2 should be filed v Department of Heath and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lizzie Barns Augustus Jones ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1010 Kenneth St., Indian Head, Md. 20640 Melvin E. Jones, Sr. Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) March 20, 2008 Zion Baptist Church Welcome, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 Hawthorne Road, Indian 21. Signature of Funeral Service License M00668 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUITIPLE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28h. Time of 28c. Injury at Work? Certification: (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State 31. Date filed (Month, Day, Year)

Registrar MAR 1 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month March **Physician** 1^{Day} 2008 1:00p M LEONOR ZELAYA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Ye June 24, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 □ M 2 🖫 F 1929 El Salvador 78 565-04-8374 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No MD Rockville Director Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20853 United States 12630 Viers Mill Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 ☐ No Specify: Salvadorian White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event Be Julia Zelava 2 Manuel Herrera 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13807 Emerson Drive Hagerstown, MD 21740 Hector Martinez (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 14, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Memorial Pk: 2008 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYFLOBLASTIC LEVKEMIA ACVIE 2 MOS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MYELOFIBROSIS 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performed? res 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 20 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er deat To the Funeral Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

vision or Vital Records, P. Leonor To the Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAR 1 8

29b. Signature and title of certifier

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

MARCH 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 705 A Edward Zimmer Louis 3 17 08 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death alisbury Wicomma pastal Hospice At The If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Days 1 **X** M 2 □ F 094-01-4935 5/22/1910 97 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Salisbury Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 30159 South Hampton Bridge Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No white 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) A & P Grocery Store store manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Regina Heckinger Louis Zimmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30159 S. Hampton Bridge Rd., Salisbury, MD 21804 Elizabeth L. Darcy/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Springhill Memory 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/08 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) <u>Gardens</u> 22. Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 Approximate

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

burial-trar asr for signed by the certificate

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

After t **Hospital or Attending**

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

State Registrar

29b. Signature and tittle of certifier

+ Hunty WARLS 31. Date filed (Month, Day, Year) MAR 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

shock, or heart failure. List only on		Onset and Death
Immediate Cause (Final disease or condition	DEMENTIA RND STAC	C-Z
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions col	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death ((Check only one)
overminor?	Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 27. Manner of Death Datural 5 □ Pending 2 □ Accident investigation		3d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Certifying Phy (Check only 2 ☐ Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, at iner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. Id at the time, date and place, and due to the cause(s)

29c. License number

2005 2410

29d. Date signed (Month, Day, Year)

BUR 1733 SHUSBILLYIND 21802

03-17-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health Andrew / Department / 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Menth Year 5 PM Allen **Physician** (1) March 2008 naymond /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner H Mor 10 105pital Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. **Funeral** Min. 1 X M 2 □ F 64 1943 NĴ July Director 211-34-5247 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a.4 etc... any injury or other traumatic event, the Medical Economics. 10d. Inside City Limits 10c. City, Town or Location 10a, State MD Baltimore Phoenix 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 13 Brocster Court 21131 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use setting) / Independent Elementary/Secondary (0-12) College (1-4or 5+) 5+ Consultant Independent Consulant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond A. Allen Jr. Beatrice Clara Messinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerilyn K. Allen/Wife 13 Brocster Court, Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 04/03/2008 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Rd Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dladder tastatic 6 months carcin oma **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 ☐ Yes 2 № No 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. Director 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 27, 2008

State Registrar

DHMH 17 Rev 1/2001

ADAU 5UMN4 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sumpdo

RES-000

600 N. WOLFEST, BALTIMORE, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ March 27, 2008 0138 hrs TYRONE BAHIA Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) University of Maryland Medical Center 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min Months Days MARYLAND 2-27-1989 Director 19 1 X M 2 F 213-23-4258 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No BALTIMORE or items 23a or 28a-f show must be notified at once. N/ABaltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Fleath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. MD 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA 21223 112 S. FULTON AVE. 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes BLACK Specify: 1 Yes 2 X No specify: If Yes, Give Year Widowed 4 Divorced 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) FOOD COOK -0--9-18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSE BAHIA TYRONE J. ADAMS Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 112 S. FULTON AVE. BALTIMORE, MARYLAND 21223 ROSE BAHLA (MOTHER) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from Stat DUNDALK, MARYLAND 1 X Burial 2 Crem 4-3-2008 MT. CARMEL CEMETERY 4 Donation Other Specifi Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature HIBM MARYLAND 21217 RALTIMORE MONROE ST. 1721-27 N. nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and ysician fail in List only one cause on each line **Medica** a. Gunshot Wounds of Torso and Arm Immediate Cause (Final disease Examine Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical **AMENDED** e attending physician for use as the burial -UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) Elospital or Attending Physician: 24 hours after death. Funeral Director: After this certifietely filled in by the funeral director, 25. Was case referred to medica Be Other Nursing Home 5 Residence 6 Other: examiner? Hospital: 1 DOA 2 KER/Outpatient 3 Inpatient 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Subject shot en o Mar 26, 2008 0113 hrs 1 Yes 2 ✔ No Natural 5 Pending 28f. Location (Street and Number or Rural Route Number, City Investigation Certificat 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1800 West Pratt Street, Baltimore, MD 6 Could not be 3 Suicide (Specify) Sidewalk 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie March 28, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. Registrar's Sign dre State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No L 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician BLANCHE BACHYNSKI MARCH 31 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HAVRZ Uz JOR 222 IR512 1512ENS 40412 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Bitthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕅 F Director 89 PENNSYLVANIA 153-01-5841 JAN Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b County 1 ☐ Yes 2 No Director MARYLAND HARFORD CO ABERDEEN 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code s 1 and 2 should be filed within 72 hours after death with to theath and Mental Hygiene. The theath and Mental Hygiene. The theath and the than "natural", or items 23a or so other traumatic event, the Medical Examiner must be nother traumatic event, the Medical Examiner must be nother traumatic event, the Medical Examiner. U.S.A. 700 W BEL AIR AVE. **APT 123** 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify: WHITE Specify: <u>م</u> 3X Widowed 4 ☐ Divorced Be Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) INSTRUMENT 8th grade ASSEMBLY TECH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NICK PORGORELSKI ANNA PORGORELSKI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 7918 K BELRIDGE RD, NOTTINGHAM, MD 21236 John W. Bachynski/Son permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.PETER & PAUL CEM. 04-04-08 PHILADELPHIA, PA. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME
ARERDEI arkasa 321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Goversim Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to br as a consequence of): Examine hysician and the burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has page 1□ Yes Division or Vital Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2|\(\frac{1}{2}\)\(\frac{1}{2}\) Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3∏ D0A 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Marther of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/31 08 SUP GIM M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 5. imit/h HVe Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 12:31 PM ALVUNIA BOSTON 2004 31 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD CO GENERAL HOSPITAL COLUMBIA HOWARD CO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2XXF 218-18-9516 83 JUNE 23 1924 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo MARYLAND CARROLL CO MANCHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2432 EBBVALE RD 21102-1310 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown DOMESTIC/CHILD CARE SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PAUL BOSTON HELEN G. GARDNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rena_Whitaker/Sister 2432 Ebbvale Rd., Manchester, Md., 21102-1310 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) LOUDON PARK CEMETERY 04-05-08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lipense 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. arlara 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 yours Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Breas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2☐ ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending p cate has been signed page 2 should be det tal or Attending Physician: Ts after death.

al Director: After this certificated in by the funeral director, ps To the Hospital o within 24 hours aff

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Me "k-al Examingr must be maitfind the once.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

Certification:

Medical

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year, APR 02 2008

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29b. Signature and title of certifier

A.



MO (Berlin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boste

29c. License number

D0054484

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 par doc 88/8 4-9-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Year **Physician** CHARLOTTE REBECCA BAER 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/27/1911 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2XF Months Days Hours Min. 96 Director 219-03-1230 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 □Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 3 725 MT. WILSON LANE, APT. 603 21208 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □ Yes 21X No Specify: Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY BETH EL .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 is marked other ti jury or other traumatic event, th other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY COHEN MATZ ALICE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 N. CHARLES STREET, #1303, BALTIMORE, MD ALEXANDER BAER / SON 21218 20b. Place of Disposition (Name of cemetery, exemplary or other place)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o important: if any injury or 4 □ Donation 5 □ Other (Specify) 04/01/2008 RANDALLSTOWN, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician END STAGE CONGESTIVE HEART FAILURE resulting in death) /Medical Due to (or as a consequence of) Examiner BROWMLY MITERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 2 No certificate 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 3□ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) March 29th, 20118 H45931 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STALLET REISTENSTOWN MD 25 MAIN

DHMH 17 Rev 1/2001

State

Registrar

Market M.

62. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, <

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State Registrar	31. Date filed (M	APR 0.2		egistrar's Sig	nature	10								

State Registrar

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signatule

April 100

30. Name and address of person who completed cause of death (Item 23a)

2008

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year) APR 02

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	Funeral Director		5. Social Security NT636 6. S 219–18– 1924 1		s. last birthday) 83 yr	Mont	ths Days		Min	th(MM/DD/YYYY) g. Fo	Birthplace (State or reign CountryMary1and	
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	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?	lf.				n? (Specify Yes or No Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
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	5-0036 led within 72 Hygiene. other than '	ĕ	17. Father's Name (First, Middle, Las		1 10	SISC.			Name (First, Middle,		are	
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	Box 68760 e death certificate by the attending physi ed for use as the bu	N/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr	p	etal death	n 3	Ectopic r	oregnancy	23d. Date of deli Month	very Day Year	
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	the Hos the Fur pletely	Medical C		ian: To the best of my knowledge. To the basis of examination								
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State 31. Date filed (Month, Day, Year)
Registrar APR 0 2 2008 DHMH 17 Rev 1/2001 OCME 2006

111 Penn Street, Baltimore, MD 21201

Donna M. Vincenti, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Physician /Medical Examiner **Funeral** Director

28a-f show the Medical Examiner must be notified at "natural", or items 23a or permit. Pages 1 and 2 should be filed within 72 hours after death bepeatment of Health and Mental Hygiene.
Important: If flem 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the "sectical Examinational".

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed Athors after death.

Euneral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burtal-transit Box 68760, P.0. Records, Division of Vital

Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Ам VIVIAN MARTHA FITZPATRICK MAR 2008 1045 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MARINER HEALTH AND REHAB GLEN BURNLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 1 F 218.14.0036 JUNE 6, 1924 BALTIMORE Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No ANNE ARUNDE GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 619 OLD STAGE RD. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates þ 1 ☐ Yes 2√No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **BOOKKEEPER** PLASTICS INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ JESSE WARRAM MARY_KNOX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT FITZPATRICK 619 OLD STAGE RD., GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donațion 5 ☐ Other (Specify) CROWNSY VET. CEMETERY APRIL 7 2008 of Juneral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, P.A. FINŘ **CREGOR** M01148 426 CRAIN HWY. S., GLEN BURNIE, MD nter the dise se, or compli r heart failure. Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each films. 23a, Part 1 shock, Immediate Couse (Final disease or condition resulting in deals) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ☐Yes 2☐No 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Valural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) GLEN BURNIE, HD 1401 HADISON PARK DR. 31. Date filed (Month, Day, Year) APR 0 2 32/Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

24 hours a

within 2.

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MORTH MARCH 2008 Marie Claire Fern 02:45AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours Min 1□M 2□F 349-26-7292 72 12 1936 IL Feb. Usual Residence of Decedent 10a State 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 🏖 ☐ No Freeland Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21053 1926 Bulls Sawmill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 X No Specify: Specify: 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Communication Elementary/Secondary (0-12) College (1-4or 5+) Contract Manager n/a Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle A. Ricker Ernst J. Utz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18109 Darnell Dr., Olney, MD 20832 Mary Florian/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/3/08 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Fun M¶ehael **▶**lagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CARCINOMA Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

certificate be executed Box 68760, attending physician for use as the buria Physician/Medical ed by the a detached f Division or Vital Records, P.O. signed I Completed certificate has page 2 director, Be မ this After t Certification: Attending within 24 hours after death.

To the Funeral Director: At completely filled in head. Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

death with

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical

Physician

/Medical

Examiner

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Examiner

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Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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D0017695

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year) State Registrar



DHMH 17 Rev 1/2001

08-02237 Linda Foster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	J	1- For State CF War yland / Department of Floatth and Wenter Certificate of Death		Reg.	No. 200	8 1055
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Linda Foster	l M	ate of Death	ay Year	3. Time of Death 0008 hrs
viedicai Examir ∕		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		arch 21, 20	4c. County of Death	
		Gilchrist Hospice Towson			Baltimore Cou	
Funeral Director		5. Social Security Number 254-68-1763 6. Sex 1 Months Days Hours	Min	pate of Birth(MM/DD/YYYY) 9. Bir Foreig 1944 Co	thplace (State or in ^{untry} Georgia
'n	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
nd how a		MD Harford Joppa				1 Yes 2 No
Maryland 28a-f show any d at once.	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	ntry?
with the Maryland ms 23a or 28a-f sho be notified at once		1504 Singer Road 21085			USA	
r death	Funeral	11. Marital Status 1 Never Married 2 XMarried 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I			White, etc.	ican Indian, Black,
ors afte	희	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give ki	ind of work	done 1	Specify: 6b. Kind of Business/	hite Industry
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT u	use retired)			·
within iene.	duc	12 5 pediatric nurse pra	action	ner	healthca:	re
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C		, , , , ,		Harmon	
212 ould bo d Ment s mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 19b)				e, Zip Code)
Magarh M	-	David Foster/spouse 1504 Singer Road J			085	Taura Chata
Baltimore, MD 21215-0036 bemit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", njury or other traumatic event, the Medical Examiner		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify:	Da	ate 2	20c. Location - City o	Town, State
Baltimore permit. Pages 1 Department of F Important: If i		21. So notice of Facial Service Licensee, Nonald S. Wade, Director State Anatomy B. Baltimore, MD		655 W.	Baltimore	Street
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	ZIZUI irdiac or res	piratory arrest	t, shock, or heart	Approximate Interval Between Onset and
/Medical caminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Complications Of Lithium Toxicity				Death
	-	or condition resulting in death) Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
red nsit	Exal	events resulting in death) Last Due to (or as a consequence of):				
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760, icate be executed physician and the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	у
certification	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic past 12 months? 4 Pregnant at time of death 5 Other (Specify)	pregnancy		Month	Day Year
Box 687 ne death certificate the attending perfect of the attending per	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
P.O. s that the gned by t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I.		acco use contribute to 2 ✓ No 3 Pro	,
ords, P.C w requires that is been signed t			- 1	1 Yes 24a. Was an		utopsy findings available
Sord law rec has be	Completed			autopsy perform	prior to	completion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to medical 26.Place of Death (Chook only	1 Yes 2	✓ No 1 1 Y	es 2 No
/ital	o Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other	Nursing He		esidence 6 Othe	er:
n of Vil ling Physic After this funeral dir	۲	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	? 280		w injury occurred	proscription
ttendi death.	atie	1 Natural 5 Pending Peb 26, 2008 1500 hrs 1 Yes 2 ✓	No me	dication		· · ·
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family			reet and Number of R ite) ad, Joppa, MD	ural Route Number, City
Hospits 4 hour funera		29a. Certifier 4 Contitution Distriction. To the best of multipopulation double accurred at the time date and plan				ted.
o the Fithin 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plat one) and manner stated.	curred at the	e time, date ar	nd place, and due to t	he cause(s)
F 3 F 3	ž	29b. Signature and title of certifier 29c. License number		1	29d. Date signed (M	
		Part (Sulfall, M)			March 21, 2008	
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD	21201		
Sta Regist	_	31. Date filed (Month, Day, Year) APR 0 2 2008 32 Registrar's Signature			OCME	
regist	إبنت	DI II O M MACA PARTIES			- VIVIL	

2. Date of Death

Month

3. Time of Death

1. Decedent's Name (First, Middle, Last)

and Division or Vital Records, P.O. Box 68760, After this

3:58 P.[™] March 28, 2008 Tontice Ann Ferrara 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Center Baltimore City 5. Social Security Number 1f Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State Childre) 6. Sex 7. Age (In yrs. last birthday) Months 1 ☐ M 2 🔀 F Sept2,1935 213**-**32-9106 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Dunda1k 10e. Street and Number 10g. Citizen of What Country? Apt 410 10f. Zip Code 7795 Peninsula Express 21222 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Service Worker Service Industry 17. Father's Name (First, Middle, Last) (unk) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Lee Fraley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Windy Branch Way Kimberly Byers-Suzer Edgewood, Md.21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4-2-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 21222 MI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ADATIC ANGUCISM LV57VLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown COLD 1 🗌 Yes 2□ No Completed CAD 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo **XX**ER/Outpatient 3 □ DOA To the Hospital or Attending Pleating 24 hours, fer death.

To the Funeral Director, After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and otle of continer 051715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rown, Marie 3730 Face FALL WAS 31270, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 02 2346 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** 5.05P MARCH 30 8005 FALCONER JOANNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard **Lorien Nursing Home** If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F 78 Director 217-46-0916 Washington, D.C Jul 22, 1929 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show oldcal Examiner must be notified at 1 ☐Yes 2 No Director MD Columbia Howard 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 6334 Cedar Lane 21044 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exa<u>miner must</u>. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph B. Lathrop Catherine W. Lathrop မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6757 Flapjack Lane Columbia, MD 21046 Tanis Hadley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr 01, 2008 Baltimore, MD 5 ☐ Other (Specify) **Bayview Crematory** Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1401293 Approximate Interval Between Onset and Death 23a. Part1. Ent. The dixtrie, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence # **Physician** /Medical Examiner Due to or as a consequence of: years Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the ! as 1 use IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a detached f 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate has performed' Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this al or Attending Physical States death.

In Director: After this din by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Speple MD NARCH 31 2008 D0053150 em 23a) (Type, Print)
9650 SANTIAGO M) SUITEIIO GLUMBIA
ND ZIOYS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sin ALLINALA GUDTA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 0 2 2008

Greeker

32. Flegistrar's Signature-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:304 Grenier mma City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death ummit Park CATONS VILLE Health & Saltimore 8. Date of Birth (Month, Day, Jan 3, 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Hours 1 ☐ M 2 🔀 F 76 1932 150-24-7632 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ∐Yes 2√∏No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 1502 Frederick Avenue Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry St. Gabriels Elementary/Secondary (0-12) College (1-4or 5+) 12 cook Retreat House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Titus Edward Bickert Emma Fort 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daphne Zappardino/granddaughter 1021 Stormount Circle Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5- Other (Specify) 21. Signature of Euroral Service Licensee State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andlovescujo 5005 Due to (or as a consequence of): Hhorsele 195 Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): obstruc Chronic Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Iniury

Physician /Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine burial-transi the use as ó signed by the a Id be detached f page 2

that the death certificate be executed

Box 68760

P.0.

Division or Vital Records,

Physician:

Physician/Medical **Q** Completed Be ဥ After this funeral of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral Certification:

1 Natural 2 Accident 3 ☐ Suicide

29a. Certifier

(Check only

Medical

State

6 Could not be determined 4 Homicide

(Month, Day Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baskara repeale 31. Date filed (Month, Day, Year)

APR 0 2 2008

3455 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** March 24, 2:32 PM M Louise Gilmer 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Yrs Oct 7, 1914 229-07-3749 93 Director West Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County , or Iteme 23a or 28e-f show the Madical Expoduer count be notified at 1 ☐ Yes 2√ No Director MD Davidsonville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3913 Birdsville Road 21035 IISA Funerai 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. nit. Pages 1 end 2 should be filed within 72 hours after entment of Health and Mental Hygiene.
ortant: If item 27 le marked other then "neturel", or ites Injury or other traumatic event, the Maracal Exertime 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Chrysler Corporation administrative assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peachy H. Gilmer Mattie Fertig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James A. Herbert/trustee 11197 Lakeside Drive Dunkirk, MD 20754 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or once. 4 XDonation 5 Other (Specify) 21. Sign fur of Eunera and Censee de Direct r State Anatomy Board 655 W. Baltimore Street 21201 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** neumonio /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a consequence of Physician/Medical Examiner use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours at To the Funeral D completely filled it 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0040904 Money 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mard Lane, Annyolis, MD 21403 D ing M.D. 12094 32. Registrar's Signature bank! 31. Date filed (Month, Day, Year) APR 02 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:28 PM 12008 Paul James Gorski 29 March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital N/ABaltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 218-44-2385 62 4-29-1945 Maryland Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No **Funeral Director** Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 Elrino Street 21224 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) N/A Western Electric Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Garfield G. Gorski Agnes D. Swieczkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. <u> Garfield Gorski - Brother</u> <u>323 Elrino Street Baltimore, MD 21224</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 4-2-2008 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myormaial Infaction 20 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page perform 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury nours after death.

neral Director: A
y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours af

To the Funeral D

completely filled i Hospital 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 29, 2000 AT2438946 Julnan Escanio

DHMH 17 Rev 1/2001

Registrar

ESCANIU 31. Date filed (Month, Day, Year) APR 0 2 2008

Belinda

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D.



Union Memorial Hospita.

			For State Registrar	State of Marylar		artment of Health and rtificate of Death		giene Reg. No	000	10557
	W.	£4.	Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
4	Physicia /Medic		Sharon	Ann	Gib	son	March	30		4:41 P.M
	Examin		4a. Facility Name (If not institution, give	treet and number)		4b. City, Town, or Location of Dea	th	4c.	County of Death	
***			Bayview Medical			Baltimore C				
}~	Funeral Director		218-56-1824	7. Age (In yrs. 5)	**	If Under 1 Year If Under 24 Hrs Months Days Hours Min		v. Year)	l Cou	place (State or Foreign intry) y Land
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	tor	Md. Baltim	ore I	Dundal	k			İ	1 ☐ Yes 2√CMNo
	r 28s	Irec	10e. Street and Number		Jundan	10f. Zip Code		10g. Cit	izen of What Cou	intry?
	th with	aiD	7125 Holabird	Avenue		21222			U.S.A.	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after daath with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Slatus 1 Never Married **Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2♥ No Specify:	Specify Yes or No into Rican, etc.))+	14. Race - Amer Black, White Specify: Wh	, etc.
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Z	2 should be and Mental is marked a	ပို	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street and Number or F			or Town, State, Z	in Code)
	1 and 2 s Health ar tem 27 is other trau		Troy J. Gibson			Holabird Ave				
altimore,	of He of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery, cre	osition (Name of matory or other place)	Date		ocation - City or 1	
Ë	Pag tment tant: jury c		4 ☐ Donation 5 ☐ Other (Specify)	C1		vill VA Cem 4-				
Ball	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Funeral Service License	land		2. Name and Address of Facilika 201 Dundalk A				
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	/Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):	arcinoma				
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9	rtifica ng ph	Medi	IE ECMALE.	-						-
Вох	death certifica attending phate of for use as t	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet	al death 3[Ectopic pregnancy			23d. Date of deli Month	very Day Year
o.	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transi	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				
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=======================================	10 CT	Con					perf 1 ☐ Yes	ormed? 2⊠N	death? 1 ☐ Yes	2 🗆 No
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Division of	if or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At l building, etc. (Spec	home, farm, st		28f. Location City or To			ıral Route Number,
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	Vilhin 2 Vilhin 2 To the	Me	29b. Signature and title of certifier	and marrier states.		29c. License number		29d. D	ate signed (Monti	h, Day, Year)
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	H		30. Name and address of person who o	ompleted cause of death (Ite	om 23a) (Type	Print) 1 Ce A e NUL	RIAL	. ^-	MI	21221
52	Sta	ate.	31. Date filed (Month, Day, Year)	32, Registrar's Sign	nature	Le The Time	ודעשכי	1))	IL III	·
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08-02233 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 10558 Marvin Glendell Hill State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 20, 2008 1915 hrs MARVIN GLENDELL HILL Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A Sinai Hospital **Baltimore** 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (in vrs. last birthday) **Funeral** oreign Months Davs Hours Director Country) MARYLAND 1-17-1969 214-86-9818 2 1 X M 39 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Yes 2 No or 28a-f show BALTIMORE N/A notified at once MD 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 2619 W. BELVEDERE AVE APT TD 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married Married Yes 2 X No Specify: BLACK 1 Yes 2 X No specify: Divorced If Yes, Give Year 3 Widowed Examiner 5 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical 21215-0036 HOME IMPROVEMENT -0-LABORER -12-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUSIE O. EDWARDS Be MARVIN HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN EDWARDS Baltimore, MD 189 S. PORTLAND AVE. #2 BROOKLYN, NEW YORK 11217 Date 20c. Location - City or Town, State 20h. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cren ation 3 Removal from State 3-29-2008 BALTIMORE, MARYLAND WOODLAWN CEMETERY D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fu 1721 - 27N MONROE_ST RALTIMORE 23a. f at I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** fail re. List only one cause on each line. Between Onset and Medical Death a. Alcohol and Methadone Intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/8/08 amh X UNPENDED attending physician or use as the burial Box 68760. IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown letached for Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 No 3 Probably 4 V Unknown Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? page Yes 2 No ✓ Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital æ Other; examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this ٩ 1 Yes No After the 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 Natural Yes 2 X No 24 hours after death. Funeral Director: neral Director: Pending Fnd 3/20/08 Fnd 6:50 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State 2500 W Belvedere St. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined Baltimore. (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifie March 21, 2008 O.C.M.E.

Registra:

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

egistrar's Signat

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2008

Carol Allan, MD

31. Date filed (Mon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh 9878 4-2-08 vt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O3 Year William H. Hofstetter 3: 23 PM 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Baltimore Medical Univ of Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□ F Months Days Hours Min Yrs. 10/29/1928 Maryland 79 <u> 214-26-0423</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Kingsville 1 Yes 2 No Baltimore - Bradshaw Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 U.S.A. 7457 Bradshaw Road 12. Was Decedent Ever in U.S. Amed Forces? 1 X) Yes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 20 Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Fullerton Supply Co. Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H. Hofstetter, Sr. Dorothea V. Karcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Hofstetter (wife)
20a. Method of Disposition 7457 Bradshaw Road - Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 03/31/2008 Bel Air, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses as 21087 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Fc. Lire Renal D273 Due to (or as a consequence of): Thoracochdomnel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stroke 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1. Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, 9 certificate To the Hospital or Attending Physician: Pis funeral After safter death.

I Director: Af
d in by the fur within 24 hours To the Funeral

Physician

/Medical

Examiner

Funeral

Director

a 23a or 28a-f show wat be notified at

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 le marked other than "natural", or Ite

permit. Pages I Department of H Important: If its eny injury or ot once.

Physician

Baltimore, Maryland 21215-0036

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Certification:

MD

death with the Maryland

DHMH 17 Rev 1/2001

State Registrar

ADRIAN HADING MI 31. Date filed (Month, Day, Year) APR 0 2 2008

30. Name and address (f person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

P22206

22

29d. Date signed (Month, Day, Year)

S Green A Pathmore 40 2120

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 - State Registrar	State of M	aryland /		artment rtificate			and M		giene	008	0561
			1. Decedent's Name (First, Middle, L.	ast)		/					2. Date of Dea	ath	V	3. Time of Death
	Physici /Medio		C-ER ALC	. Male	. H	-an	Lin				Month	Day / 7	Year 2009	10:25 AM
1	Examir		4a. Facility Name (If not institution, gi	ve street and number,			4b. City, 7	Town, or	Location of	of Death		4c. Co	unty of Death	
			Dennett Road Man	or			Oak.	land					Garrett	
	Funeral		,	Sex 7. Aq 1. 1	ge (In yrs. last		If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da)	v. Year)	Coun	
	Director		210 04 0211	TIZM ZUF	89	Yrs.					2-15-19	919	Mt. S	Storm, WV
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	f ehc	5	MD Garret	t	Oakla	nd								1 Yes 2 □ No
	158 108 108 108 108	Director	10e. Street and Number				10f. Zip	Code			T	10g. Citizer	n of What Coun	itry?
	3e or		113 Mary Drive				215	550				USA		
	me 2	Funeral	11. Marital Status	12. Was Decedent		13.	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	. 14.	Race - Americ	
9	or its	Ē	1)SNever Married 2 Married	Armed Forces' 1 Yes 2 If Yes, Give			ires,spec 1∐ Yes 2j		Specify:	i, Puerto	Hican, etc.)		Black, White,	
21215-0036	d within 72 hours efter death with the Marylend Jene. r then "neturel", or iteme 23e or 28e-f ehow the Medical Examinat must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			10163 4	A A I NO	эреспу.			3,	pecify: Wh.	ite
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2	Hygie other		12 17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	First, Middle,			
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Maryland	D D M	၉	19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailir	ng Address	(Street a	nd Numbe	or or Rura	al Route Numbe	er, City or T	own, State, Zip	Code)
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altimore,	Page nt: # rry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Spec				Cemete			3-21-	-08	Mt. S	Storm, I	√V
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1	/Medical		resulting in death)	Due to (or as	a consequen	ce of):		2			- 0			000
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Вох	death certificate be executed e attanding physicien end nd for use es the buriel-trensi	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Je					230	d. Date of delive	ку
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of Vital Records, F	8 6 9	þ	Part II. Other significant conditions	contributing to death t	out not resulting	g in the u	nderlying ca	iusė give	n in Part I.		23e. Did to			ne cause of death? ably 4 □Unknown
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æ	The lev ste hes page 2	E										rmed? 2⊠No	death?	npletion of cause of 2□ No
<u>a</u>	rtifice	Bec	25. Was case referred to medical						26. Place	of Death	Check only o			
<u>_</u>	Physician: r this certific rel director,	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ERV	Outpatien	it_ 3□ DO/	A Othe	E 4 Nu	rsing Ho	me 5 Resid	dence 6	Other (Specif)	()
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Si	Attending r deeth. ector: After by the fune	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	he l			М		′es 2 🗆 l	-				
	or At ofter of Direct in by	Certification;	4 Homicide determined	1 25e. Place of in	jury - At home, tc. <i>(Specify)</i>	, farm, str	eet, factory,	office			City or Tow		vumber or Hura	l Route Number,
_	spital ours 6 nerel 1 filled		29a. Certifier 1 Certifying P	hysician: To the best	of my knowled	doe, death	occurred a	at the tim	e. date an	d place	and due to the	cause(s) an	nd manner as st	ated.
	To the Hospital or Attending Physician: The inviting 2 hours effect death. To the Funeral Director: Atter this cartificate he completely filled in by the funeral director, page	edical		miner: On the basis of and manner st	f examination	and/or in	vestigation,	in my op	inion, deal	th occurr	ed at the time,	date and pl	ace, and due to	the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	r/l		,	29c.	License	number			29d. Date s	signed (Month,	Day, Year)
			1/Llyth	1/auss	10	n	1	10 6	18	01		3/1	718	
	2		30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print)							, 1
			FEN R. BUCZ	yrski h	- ~ <i>j</i>	3 11	1, 4	164	57.	541	TE (ogk	-land	mD 5122
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		20							
	riegisti	uı	APR U Z ZUU	O A BURGAR	A.F.	64000	20							

DHMH 17 Rev 1/2001

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

TOWSON

Months Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

***************************************	Physicia /Medic Examin	a
	Funeral	

1 - For State Registrar

10a. State

1. Decedent's Name (First, Middle, Last)

GILCHRIST HOSPICE

Social Security Number

215-68-0067 Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

1**∑**M 2□ F

STEVEN M. HOGAN

Director ŏ

	the Mar 28a-f sl	햕	MD	BALTIMO	RE	PERRY	HALL			
	h with the Mar 23a or 28a-f si st be notified	al Director	10e. Street and Nur 9308 SNY	nber DER LANE			10f. Zij	21128		10g. Ci
920	s 1 and 2 should be filed within 72 hours after death with the Ma Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examinat must be notified	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed	ed 2 X Married	12. Was Decedent Ev Armed Forces? 1 Tyyes 2 □ No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \(\textstyre \text{Yes}	dent of Hispanic Origin? cify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or N erto Rican, etc.)	lo-
21215-0036	filed within 72 hours Hygiene. Ither than "natural", ant, 'no Medical Eva	Completed	(Spec	15. Decedent's Educify only highest grade	cation e completed) College (1-4or 5+		life. DO NOT u	ork done during most of w		16b. F
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Balt	permit. Page: Department o Important: If i any Injury or once.		21. Signature of	n ral Service License	90			nd Address of Facility BELAIR RD	HILLER-DI BALTI	
	Physician /Medical Examiner		23a. Part 1. Enter to sheek, or hea Immediate Cause disease or condition resulting in death)	Final	cations that caused the cause on each line. Due to (or as a	0 (0)	1 C	de of dying, such as card	iac or respiratory	arrest,
760, <	ate be executed sysician and ne burial-transit	ical Examiner	Sequentially list confirmant, leading to im Cause (Disease or that initiated events resulting in death) I	injury	Due to (or as a					
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rds, P	juires that n signed b ild be deta	ž	Part II. Other signif	icant conditions con	tributing to death but	not resulting i	n the underlying o	cause given in Part I.		tobacco Yes 2
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-	Physiclan: Th r this certificate ral director, pag	o Be	25. Was case reference examiner? 1 Tyes 2 P		lospital: 1	t 2 🗆 ER/O	utpatient 3 □ De	Other	Death <i>(Check only</i> g Home 5 ☐ Res	
Division o	tending Physeath. or After this the funeral dir	Certification: T	27. Manner of Deat	n 5 ☐ Pending investigation 6 ☐ Could not be	28a. Date of Injury (Month, Day,		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	∍ how inju
	oital or Att		3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Injur building, etc.	(Specify)		·		own, Stat
	To the Hospital or Attending within 24 hours ar er death. To the Funeral Director, After completely filled in by the funer.	Medical	29a. Certifier (Check only one)	2 Medical Examin		examination ar	nd/or investigation	d at the time, date and plan, in my opinion, death or the community of the		
	₽ ₹ ₽ Ø	-	29b. Signature and	Hothy	y Mil	7,0	1	2529		M
	ΛX,		30. Name and addr	ess of person who	mpleted cause of del	th (Item 23a)	(Type, Print)	1 les	to the	Voto

4c. County of Death BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 2/11/1955 10d. Inside City Limits 1 □Yes 2X No itizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE Kind of Business/Industry **BGE** n Surname) or Town, State, Zip Code) HALL, MD 21128 ocation - City or Town, State ALTIMORE, MD FUNERAL HOME, INC E, MD 21206

Date of Death
 Month

MARCH

27, 2008

 P^{M}

5:43

Approximate Interval Between Onset and Death

Year

23d. Date of delivery Month

use contribute to the cause of death?

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No

6 Other (Specify) ury occurred

and Number or Rural Route Number,

s) and manner as stated. nd place, and due to the cause(s)

Pate signed (Month, Day, Year)

17 Ch 28, 2008

m12120x W. H. K. Loy 6 gm (670)

ORIGINAL

31. Date filed (Month, Day,



Registrar

OHNSTON

To the Hospitary ... within 24 hours a 'er death.
To the Funeral Director: After this o Medical Certification: To 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mallika. A March 31st 2008 P 22257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALLIKA ANGITIPALLI . ST AGNCS HDSPITAL 900 S. CATON AUENUE. BALTIMORE, MD - 21229 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Contract of the state of APR 02 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

08-02457 Toby Johnson		Pleas		r Print in E of Maryland			n k. Ensure Health and			egible.	200	8 1056 ^L
	R	- For State egistrar			Cer	tificate of	Death			Reg. No.	200	
Physiciana Medical Examine		I. Decedent's Name (Fi Toby Lamont							2. Date of D Month March 2	Dav	Year	3. Time of Death 2027 hrs
4	Í	a. Facility Name (if no Sinai Hospital	t institution, give	e street and number	er)		4b. City, Town, or Baltimore	Location of Dea	ath	4c. C	ounty of Death	
Funeral Director	1	5. Social Security Numb 213–86–9816		X 7.		ast birthday) 36 Yrs	If Under 1 Year Months Days		Irs. 8. Date of 07–31-		Foreig	th place (State or in untry) MD
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r death with the Maryland or items 23a or 28a-f sh Emust be notified at once	칾	10e. Street and Numbe	er				10f. Zip Code			10g. Citizer	of What Cou	ntry?
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2 hours "natur	ן נפ	15. Decedent's Educa Elementary/Seconda		College (1-4		during m	nt's Usual Occupat lost of working life			16b. Kin	d of Business/	Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan		12th	, (1 12)	9-(.	,	Self-Emp	oloyed			Home	Improva	ment
215-0 be filed v ntal Hygi rked oth rent, the J		17. Father's Name (Firs Rommie Gibsor						18.Mother's Na Vivian .	me (First, Midd	le, Maiden Su	irname)	
tould be d Ments is mark		19a. Informant's Name	/Relationship (T				g Address (Stree	t and Number	or Rural Route		or Town, State	e, Zip Code)
, MD and 2 sh ealth an em 27 i	ŀ	Sheila M. Job 20a. Method of Disposi	· · · · · · · · · · · · · · · · · · ·	fe	20h		Edgewood Ro		imore, M		cation - City or	Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Ba Completed by Elimeral Director		1 X Burial 2	Cremation 3				herplace) Cemetery		- 4 - 08		imore, M	i i
altin mit. P. partme ury or	1	Donation 5 21 ature of Funera			0 /	22. 1	Name and Address	of Facility W	ylie Fune	ral Hom	e P.A. o	f Balto. Co.
	1	Ran(WAL	MU.	Lefter death		O Liberty					Approximate Interval
Physician 'Medical		failure. List only o	one cause on ea			. Do not criter	nie mode or dying,	3001 03 001010	o or respiratory	417000, 011001	, or mount	Between Onset and Death
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Records, The law require: cate has been sig									_ _ p	utopsy erformed? es 2 No	prior to death?	completion of cause of 'es 2 No
Vital Recysician: The his certificate director, page	۱٠	25. Was case referred examiner?					26.Place	e of Death (Che				
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Division of Vital Records, P.O. 10 points and Vital Records, P.O. 24 hours after death. Retrains criticate has been signed by Functal Director. After this certificate has been signed by teldy filled in by the funeral director, page 2 should be detacted.		2 Accident 3 Suicide 6 4 Homicide	Could not determine	be 28e. Place o		nome, farm, stre	eet, factory, office t	ouilding, etc.			d Number or R	tural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours abredeath. To the Funcal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring addition. To Bo Compileted by Division Modern		29a. Certifier 1 Ce		ian: To the best o	f my knowled	ige, death occu	rred at the time, d		and due to the	cause(s) and	manner as sta	ited.
	1	29b. Signature and title	e of certifier	and manner state	ea.		29c. Licens				-	onth, Day, Year)
	-	30. Name and address	of person who	completed cause	of death (Iter	n 23a)	O.C.	ivt.⊑.	··-··	iviard	h 29, 2008	
6		Margarita Kore	ell MD. As	ssistant Medic		ner 111 F	Penn Street, B	altimore, M	ID 21201			
Stat Registra	~	31. Date filed (Month, L		130	oual s olyrial	Soul	£					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1:00 PM 2008 Jacobi Jackee Lori March 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Hospice Center Birthplace (State or Foreign Country)
 PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05.12.1934 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 🕱 F Months 73 177.26.6065 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 Yes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21239 5637 Purdue Avenue Apt. D 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Marv Fassett William Brown McCracken 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5637 Purdue Avenue Apt. D Baltimore, Francis A. Jacobi/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 04.01.08 Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardio my opath Fud - Stage ments disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the

physician and the burial-tran attending pl sate has been signed by the page 2 should be detached funeral director, n 24 hours a er death. le Funeral Director. Aff bletely filled in by the fun within 24 hor To the Fune completely fi

Physician

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Funeral

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28a-f shov

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Certification: To

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modest Exprimer must be nothered

Health a

permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.

Physician

/Medical

death with the Maryland

Baltimore, Maryland 21215-0036

Jacke

/Medical

Registrar

29b. Signature and title of certifier

(Check only one)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year) MArch 31, 2008

30. Name an ad ress of person who completed cause of d th (Item 23a) (Type, Print)

(Item 23a) (Type, Print) 6701 N. Charles St. Balts Md 2120x 6 BMC

31. Date filed (Month, Day, Year) APR 02 2008

32/Registrar's Signature

08-02505		Please Type or Print in Black Indelible Ink. Ensure All Cor		ible.	
Tyree M Johnson		State of Maryland / Department of Health and Mental	Hygiene	200	8 1056
	F	For State Certificate of Death		J. No.	
Physician	~	1. Decedent's Name (First, Middle,Last)		Day Year	3. Time of Death
Medical Examine		Tyrere Johnson	March 30, 2		1241 hrs
,		 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of De University Hosiptal 4b. City, Town, or Location of De Baltimore 	eath	4c. County of Deat	1n
	4		III. In Date of Birth	(MM/DD/YYYY) 9. B	rthplace (State or
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Director		777-78-7007 1 MM 2 F Yrs. 9 21	Min. June	(, 200) 0	ountry) Maryland
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Aland land	ទ្ធ	Meryland My			
Mary Mary 1288	Director	Manyland NA 10c. City, Town or Location Baltimo, 10c. Street and Number 10f. Zip Code 21202	10	g. Citizen of What Cou	intry?
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th wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 14. Never Married 2 Married Armed Forces? 15. Was Decedent of Hispanic Origin? 16. If Yes, specify Cuban, Mexican, Pure Married Process		14. Race - Ame White, etc.	rican Indian, Black,
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36 in 72 than	Be	Elementary/Secondary (0-12) College (1-4 or 5+)		NVF	-
with with her t	Completed	17. Father's Name (First, Middle, Last) 18.Mother's N	lame (First, Middle, M	laiden Surname)	,
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21215-0036 Total be filed within 7 Mental Hygiene. Is marked other than itic event, the Medical	라	19a. Informant's Name/Relationship (Type, Print)			e. Zin Code
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X1 is marked other than "natural", or items 23a or 28a-f show any injury or other traunsatic event, the Medical Examiner must be notified at once.	ıŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location City of	r Town, State
Baltimore, pernit. Pages I a Department of He Important: If ite	П	1 Burial 2 Cremation 3 Removal from State Crematory or other pare),	4/2/20	Martland	Mamila 1
Baltimo Permit. Pag Department Important: njury or of	I,	4 Donation 5 Other Specify.	71108	VVICULANI	- may yeary
Balt permit Depart Impor injury	ч	21. Signature of Furlera' Service Licentee 22. Name and Address of Facility	entren Fy	vessel 110	ne 1.1.21229
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	_7\ve. 10	st shock or board	Apploximate Interval
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xaminer	-	Immediate Cause (Final disease or condition resulting in death) a. Acute and organizing broncho neumonia asso	ciated with	bronchioliti	S Death
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68 Se as	[필	past 12 months?	egnancy	Month	Day Year
eath eath for u	န္တု	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
the d	£١	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23e. Did to	bacco use contribute	o the cause of death?
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oital Di	5	4 Homicide determined (Specify)	or Town, S		
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the caus	e(s) and manner as st	ated.
ithin the	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, date	and place, and due to	the cause(s)
F 3 F 8	울	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
1		Down my) inching. O.C.M.E.		March 31, 2008	3
x rea	ŀ	30. Name and address of person who completed cause of death (Item 23a)		J	
ioxped		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
Stat	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Registra	-	APR 0 2 2008 Chance & April 1			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RAN LILLIAN E. JONES /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** N/A Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10–8–1922 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F NORTH CAROLINA 85 220-24-0985 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21217 USA 2012 McKEAN AVE. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examines and 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married BLACK 1 ☐ Yes 2X No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -8-HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES JONES LILLIAN BELLMY ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1536 APPLETON ST. BALTIMORE, MARYLAND 21217 FRANCENA BEAN-WATERS (FRIEND) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐Removal from State METRO CREMATORY 3-25-2008 BALTIMORE, MARYLAND 4 □ Donation 5 ☐ Other (Specify) HIBNER. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part E, her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi e v ause (Final disease v ondition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and the burial-trai Due to (or as a consequence Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 21 No certificate has 1⊟ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation within 24 hours a er dea h.

To the Funeral Director A 2 Accident filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Nacon 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Johnson 6:25 AM 8005 larch /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number Examiner ashington Adventist Park Montgomer Hospital Takoma 8. Date of Birth (Month, Day, Oct 18, 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 1930 1 M 2 □ F Washington DC 577-40-3424 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ∐Yes 2√∑No Funeral Director Forestville Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20747 2752 Lorring Drive #304 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elise Collomes Henry Johnson ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 2752 Lorring Drive #304 Forestville, MD Willie Douglas/friend Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation-3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Sign dura el Funeral Servic 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD pleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part . Enter the disease, or com shock or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration (or as a consequence of): dum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Small Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Division or Vital Records, P.O. Box 68760, attending property for use as signed by the a s certificate has b irector, page 2 sl this

After

Physician

Funeral

Director

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th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

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Department of Health Important: If item 27 any injury or other trong once.

Physician /Medical

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Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be Certification: To after death.

Director: / within 24 hours after To the Funeral Discompletely filled in

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Wertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certific

29c. License number D0064024 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

7600 Carroll Ave. Takoma Park, MD 20912 L'achtchinina, MD.

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 02 2008 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 0720 Elains 03 2008 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mari MIVEYSITU Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Months unk Director 220-64-8145 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. Stateunk 10b. County unk unk 1 ☐ Yes 2 ☐ No Director unk 10g. Citizen of What Country? unk 10e. Street and Number 10f. Zip Code USA Funeral unk 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married black If Yes, Give Year or Dates: Specify: ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Greene Street Baltimore MD 21201 osilion (Name of Date | 20c. Location - City or Town, State University of Maryland Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Suneral Service Licensee Director MALL 21201 ron Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Between and Death Immediate Cause (Final complications disease or condition resulting in death) Due to (or s a consequence of) EXAMINES Suddle arres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner BY TIFICATION APPR Due to (or as a consequence of): IF FEMALE 23d Date of delivery 23b. Was decedent pregnant Year

Physician /Medical Examiner

and

attending physician

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this funeral

After

within 24 hours after death.

To the Funeral Director: At completely filled in here.

certificate be executed

Box 68760.

P.O. 1

Division or Vital Records.

Physiclan:

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"natural", or Items 23a or 28a-f shovedical Examiner must be notified at

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other traumatic event,

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than '

permit. Pages Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

burial-tran as the l nse for detached signed by page 2 s director,

Physician/Medical 2 Completed Be 2

Certification:

Medical

in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

5 ☐ Other (specify)

3 ☐ Ectopic pregnancy

Day Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death? 2□No 1 Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Nopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No

4/2008

28b. Time of 28a. Date of Injury 109AM

Q

28c. Injury at Work? 1 ☐ Yes 2 X No 28d. Describe how injury occurred

Struck 28f. Location (Street and N City or Town, State)

21201

29a, Certifier (Check only one)

27. Manner of Death

1 Natural

Accident

4 ☐ Homicide

3 ☐ Suicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 | Pending

investigation

determined

6 ☐ Could not be

29c. License numbe

29d. Date signed (Month, Day, Year) 008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e

Danielle Dabbs 31. Date filed (Month, Day, Year) APR 0 2 2008 222 S. Greene Street B-more, MD 37/Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar Amend Item	State of Ma 28b per m	ryland / Depa e,g878,04	artment of H	lealth and N Death	nental Hyg	iene eg. No. 🤈 (108	105	570
8	Physicia	an	1. Decedent's Name (First, Middle, Las Robert Earle Kendall,					2. Date of Deat Month 03	Day	2008	3. Time of 08:15	
r	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death	1	4c. Cour	nty of Death	00.10	
		90c	Kline Hospice House 5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birthday)	Mt. Airy If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		derick 9. Births	olace (State o	r Foreign
100	Funeral Director			XIM 2□F	91 Yrs.	Months Days	Hours Min.	08/08/191	6 Year)	Iowa	ntry)	
	land Sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside Cit	ty Limits
	with the Maryland a or 28a-f show be notified at	ctor	MD N/A		Baltimore						1 X Yes	2 □ No
	with the	Director	10e. Street and Number			10f. Zip Code		1		of What Cour	ntry?	
	ms 23	Funeral	1417 Glendale Road 11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	21239 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		Race - Americ		
920	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	o Hicari, etc.)	Specify: White			
2-0	"natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	king	16b. Kind of	Business/In	dustry	
121	within jene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	s Examiner	ı)		Social	Sēcurit	су	
Maryland 21215-0036	should be filed within 72 ho nd Mental Hygiene. marked other than "natu matic event, the Medical	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, I	Maiden Surr	name)	•	
ryla	12 should be finand Mental His marked of raumatic even	P	John Worthington Kendall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural R							vn State Ziu	Code)	
	ulth ar 27 is rtrau		Robert Kendall, Jr.	N.C., 278		,,, o.a.o, <u>z.</u> ,	0000)					
Baltimore,	e = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □			osition (Name of matory or other place	ce)	Date		on - City or T	own, State	
ij	a a a a		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	/)	Louden Parl	Cemetery	03/20	20/2008 Baltimore, Maryland Leonard J. Ruck , Inc.				
Ba	permit. 8 Departm Importar any injui	lig d	Dleyanana	imore, MD		iic.	Approximat					
8760,	Physician / Medical Examiner physician and physician and the prujar-transit the prujar-transit physician and the prujar-transit physician and	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	consequence of):	Hemator	Appro	Therval Between Onset and Death 2 1/2 42 42				
P.O. Box 68	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	у		23d.	Date of deliv Month	,	Year
	uires that the de signed by the Id be detached		Part II. Other significant conditions of	N. /	t not resulting in the	\	ven in Part I.	23e. Did to			the cause of o	
Division or Vital Records,	The law requi	Completed by	osteopersis	•				24a. Was a autop perfor	an 2- isy rmed? 2 1 No	4b. Were aut prior to codeath?	opsy findings ompletion of c	available ause of
Vita	Physician; The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o			2./. /	
ō	d: 5. ×	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur	y 28b. Time	of 28c. Inju		lome 5 ☐ Resid 28d. Describe h			ity) Klike M	sprite
ion	Attending r death. ector: After by the funer	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investigation				Yes 2 1 No	Fall				
N X	I or Attencater death	rtific	3 Suicide 6 Could not be 4 Homicide determined	building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (S City or Tow 14 80 RM	vn, State)			
1	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical Ce		nysician: To the best on the basis of and manner sta	f my knowledge, dea examination and/or			e, and due to the	cause(s) and	d manner as		
	To the within To the comple	Med	29b. Signature and title of certifier			29c. Licens				gned (Month	, Day, Year)	
			> /l/toll w	>		De	3)80		3/18	3/08		
_	(b)		30. Name and address of person who Kevin E. Hohl mo	completed cause of de	ath (Item 23a) (Type 300 S- Chu	ch St. 1	neddle tow	n mb.	21769			
	Sta Regist	ate rar	30. Name and address of person who Kevin E. Hohl mod 31. Date filed (Month, Day, Year) MAR 2.1 201	32. Registra	r's Signature	nells						

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mildred Kercoude March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 578-24-8332 Director 88 Jan 17, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturai", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinations and other traumatic event, I'm Medical Examinations and other traumatic event, I'm Medical Examinations. 10a State 10c. City, Town or Location Funeral Director Carroll Sykesville 10e. Street and Number 10f. Zip Code 1442 Buckhorn Road 21784 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Buck Crocker ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. I Mrs. Cindy Izadi (Daughter) 13 20b. Place of E 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky G 21. Signature of Funeral Service Licenses ▶ Paigespaights 23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Part II. Other significant conditions contributing to death but not resulting in the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Pea	arl Ge	rman				
. Print)		19b. Mailing Addre	ss (Street and Numb	er or Rural R	loute Num	ber, City	or Town, State,	Zip Code)	
(Daughter)	1324 Lis	bon Drive,	Elde:	rsbur	g, M	D 21784		
	20b. Pla	ace of Disposition (N	ame of	Date			ocation - City or	Town, Sta	ate
noval from State	I	y Gap Vet	erans	4-4-08		F1ir	itstone,	MD	
fuku	+	HÃ IGH (Box	ind Address of Facili FUNERAL 195) Sykes	HOME 8	& CHA , MD	PEL. 2178	P.A.		
tions that caused the cause on each line.	0	Do not enter the m	ode of dying, such as	s cardiac or re	espiratory	arrest,		Interv	ximate al Between and Death
Due to (or as a	conseque	ence of):							
Due to (or as a	conseque	ence of):							
Due to (or as a	conseque	ence of):							
If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal o	death 3 ☐ Ectopio					23d. Date of de Month	elivery Day	Year
buting to death but	not result	ting in the underlying	cause given in Part I	l.			use contribute t	o the caus	e of death?
						opsy formed?	prior to death?	completio	dings available n of cause of
				e of Death (C	check only	one)			
spital: 1 ☐ Inpatient	2 🗆 E	R/Outpatient 3 1	OOA Other: 4 🗆 N	ursing Home	5 🔲 Re:	sidence	6 Other (Spi	ecity) He	SPICE
28a. Date of Injury (Month, Day, 1		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □	.	l. Describe	how inju	ry occurred		
28e. Place of Injury building, etc.	- At hon (Specify)	ne, farm, street, facto	ory, office	28f.	Location City or To	(Street a	nd Number or R e)	lural Route	Number,
lan: To the best of r: On the basis of e and manner state	xaminati	ledge, death occurre on and/or investigation	ed at the time, date a on, in my opinion, dea	nd place, and ath occurred	d due to th at the time	ne cause(e, date ar	s) and manner and place, and du	as stated. e to the ca	use(s)
		2	9c. License number			29d. D	ate signed (Mon	th, Day, Y	ear)

3. Time of Death

12:45 pm

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

DC

Year

2008

Carroll

4c. County of Death

10g. Citizen of What Country?

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

USA

<u>Domestic</u>

30

1920

Physician /Medical Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

25. Was case referred to medica examiner?

5 Pending

6 ☐ Could not be

determined

1 Yes 2 10 No

27. Manger of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

To the Hospitai or Attending Physician: The law requires that the death certificate be executed April 1 Division of Vital Records, P.O. Box 68760, filled in by the fr

> State Registrar

within 24 hours a

08-01971 George Kahl, S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Kahl, Sr.	1	- For State an	end #19	te of Maryland a Per Inf (i / Departi G 878∕⊾/∄	ment of Heal	in and Menia h	пуде	Reg. N	. 20	08 1057	
Physicia	n/	Registrar 1. Decedent's Na						2. Da	te of Death	v Year	3. Time of Death 1120 hrs	
Mydical Examir			Kahl Si			4b City 7	Four or Location of F		rch 10, 20	08 4c. County of Dea		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 29 Yorkway Dundalk							Baltimore County			
Funeral		5. Social Security	Number	5. Sex 7. /	Age (In yrs. last				Date of Birth(M	II-or	Birthplace (State or reign	
ត្ត ខ្ញុំ L		212-24-	1683	1XM 2F	80 -8	Yrs. Month	s Days Hours	Min. D	ec 23,	1927	Country) Maryland	
	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
		MD Baltimore Dundalk									1 Yes 2 X No	
	5	10e. Street and Number 10f. Zip Code							10g.	Citizen of What C	country?	
		29 Yorkway 21222								USA	Tadian Dinak	
	uneral	11. Marital Status 1 Never Married 2 Married Forces? 13. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Po							Yes or No- n, etc.)	White, etc	nerican Indian, Black, c.	
	ш	1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year \$\frac{1}{4}6-47\$ 1 Yes 2 X No specify:									white	
ours aft atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give king during most of working life. DO NOT us						nd of work o	of work done unk 16b. Kind of Business/Industry unk retired)			
5-0036 led within 72 h Hygiene. other than "n the Medical E.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)						,				
	mo	11 0 18.Mother's Name (First, Middle, Last) 18.Mother's						Name (Firs	ame (First, Middle, Maiden Surname)			
215 be file ntal 15, rked o	BeC	Albert William Kahl El						eanor	eanor Ruth Mallette			
2 21 should is mai	To	19a. Informant's Name/Relationship (Type, Print) Victoria 20. Variation Print 19b. Mailing Address (Street and Number Victoria)									state, Zip Code)	
MD and 2 sho ealth and tem 27 is traumati		Virgin 20a. Method of I	ta Kan1/ Disposition	spouse		ace of Disposition (Na		Da Da		Oc. Location - Cit	y or Town, State	
Baltimore, permit. Pages I at Department of He Important: If ite		1 Burial		3 Removal from	State	ematory or other place	e)					
altin nit. Pa partmen portan			5 Other Spread Service		iroatar	22. Name an	d Address of Facility	oard (655 W	Raltimon	re Street	
m gg Eig		Kon	21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore MD 21201 23a Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onse									
50, Medical aminer hysician and chrisie transit	3.	23a\ Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart spilorer. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease										
		Immediate Caus or condition res	se (Final disease ulting in death)	Due to (or as a o			cular Disease					
		Sequentially list conditions.										
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.										
	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
	Medical	d. UNPENDED AMENDED										
'60, ate be ohysicia	Med	IF FEMALE:		23c. If yes, ou	tcome of pregn	ancy				23d. Date of de		
687(certifica nding pl	ian/	past 12 mo	ent pregnant in t nths?		th nt at time of dea	2 Fetal dea		pregnancy		Month	Day Year	
Box 6876 e death certificate the attending phy ed for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown							I as Birry		to to the source of dogth?	
P.O. 1	by PI							ırt I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
ords, P.C w requires that is been signed b should be deta	ted	Diabetes mellitus							24a. Was ar		ere autopsy findings available	
COFC law re- has be	Completed								autops: perform	ned? dea	or to completion of cause of ath? Yes 2 No	
of Vital Recing Physician: The After this certificate funeral director, page	ပြ											
	o Be	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene										
	Į.	27 Manner of	Death	28a. Date o (Month,	of Injury Day,Year)	28b. Time of Injury	28c. Injury at Work		d. Describe h	ow injury occurred		
	atio	1 V Natural 5 Pending 1 Yes 2 Accident Investigation							of Location (S	reet and Number	or Rural Route Number, Cit	
Divis al or A s after al Dire	Certification:	3 Suicide 6 Could not be determined (Specify)							or Town, State)			
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the!	ပြီ	Place Certifier and due to the cause(s) and manner as stated.										
	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.							29d. Date signed (Month, Day, Year)			
F 3 F 8	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.							March 11, 2008			
		TOUNG SECTION										
		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	Stat	31. Date filed	Month, Day, Year	32. Re	gistrar's Signatu	ire Anal e						
Regi	stra		PR 02	LUUG Allete	the All	Branke						

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

		1	For State Registrar	State of Maryland		tment of Health an <i>ficate of Death</i>	d Mer	ital Hygie Reg	- CUI	3 (10573
0	**	π,	. Decedent's Name (First, Middle, Last))				Date of Death		V	3. Time of Death
138	Physicia		Francis H.	Leach			1	Month	Day /	Year OOS	15:40 PM
Sec. 300	/Medic		a. Facility Name (If not institution, give			b. City, Town, or Location of D	eath		4c. County	of Death	
1	Examin	er i	Sun Bridge Care and			EIKTON			C	ecil	
		^	Social Security Number 6. Sec			If Under 1 Year If Under 24	Hrs. 8.	Date of Birth	agel	9. Birthp	ace (State or Foreign
	Funeral Director			M 2□F 88	Yrs.	Months Days Hours	Min.	(Month, Day, Y	3,1919 California		
			Jsual Residence of Decedent					11			
	ylan		10a. State 10b. County		own or Loca	tion				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a-f s	i i	Maryland Cecil	6	EIKto	7					
	ith the Marylar or 28a-f show	Director	Oe. Street and Number			10f. Zip Code		10g	. Citizen of		itry?
	th will		1 Price Lane			21921				USA	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hispanic Origin res, specify Cuban, Mexican, P	? (Specify uerto Rica	Yes or No- an, etc.)		ce - Americ ck, White,	
9	or its	린	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		Yes 2 No Specify:			Specif	y: W	nite
5-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show circal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: WWII		1.11		10	b. Kind of B		
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121	filed within Hygiene. other then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	-	ety Inspect	2		Sto	ate	
121	Hygie ther nt, II	e Co	17. Father's Name (First, Middle, Last)		000			irst, Middle, Ma		_	
an	ntal ed o	ă	Leo Leae	h		C	a cri	e Ed	1	070	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the M	ို	19a. Informant's Name/Relationship (T)		19b. Mailing	Address (Street and Number of					Code)
Z	ges 1 and 2 should be filed within 72 hours after death with the Maryla to Health and Martal Hygiens. I set them 27 is marked other than "natural", or itema 23s or 28s-f show if Item 27 is marked other than "natural", or itema 23s or 28s-f show or other traumatic event, the Modical Examination must be notified at		Ellen Billingsiea	/	5500	Norrisville 1	301	white	Hall	MD	2116)
စ်	permit. Pages 1 and 3 Depertment of Health Important: If Item 27 any Injury or other tr. once.	1	20a. Method of Disposition	20b. Plac	e of Disposi	tion (Name of	Date	20	c. Location	- City or To	own, State
altimore,	Pages nent of I int: If It		1 Burial 2 Cremation 3 II	Removal from State	etery, crema	naction Solvices Ap	ril 2.	2008	Hand	over,	MD
幸	permit. Pag Depertment Important: I any Injury o	1	21. Signature of Funeral Service Licens		22.	Name and Address of Facility	Ardon	+ Crem	aution	Secui	ces
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t. jet		-	23a Part1 Foter the disease or comp	t,		Approximate Interval Between					
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	Physician /Medical		disease or condition resulting in death)	a CAMIO PU	WC MU	my Annes					DAZ
	Examiner		A .	BLADDER							YEARLS
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequer		C 100 103					1,74,102
11	nsit insit	ᄪ	cause. Enter Underlying Cause (Disease or injury								
hr.	exect n and al-tra	Examin	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):						
8760,	cate be executed oblysicien and the burial-transit		l	d							
9	requires that the death certificate veen signed by the attending physinould be detached for use as the	Physician/Medical									
Вох	leath certifica attending ph I for use as th	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc		-1				ate of deliv	
B	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat		Ectopic pregnancy Other (specify)			M	Ionth	Day Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown							
ο. Ο.	w requires that been signed to should be deta	by P	Part If. Other significant conditions co	ontributing to death but not resulti	ing in the un	derlying cause given in Part I.		23e. Did toba	acco use cor	ntribute to	the cause of death?
ğ	quire in sig uid b	B						1 ☐ Yes	2 □ No	3 Pro	bably 4 Nnknown
၀		Completed						24a. Was an autopsy	24b	. Were aut	opsy findings available ompletion of cause of
Re	sician: The law s certificate has t firector, page 2 s	E						perform	ed? No	death?	2 □ No
tal	an:] tifical	0	25. Was case referred to medical			26. Place of	f Death (0	Check only one			
>	Physician: this certificant	To B	examiner? 1 \(\sum Yes \) 2 \(\sum No \)	Hospital: 1 Inpatient 2 EF	₹/Outpatient	3□ DOA Other: 4Nurs	ing Home	5 Resider	nce 6 🗆 O	ther (Spec	fy)
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28	d. Describe hov	v injury occu	ırred	
ion	f A P	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	in july	M 1 Yes 2 No	0				
	C = : 0				e, farm, stre	et, factory, office	28	f. Location (Stre City or Town,		nber or Ru	ral Route Number,
Vis	Attending or death.	iffic	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At nom				-			
Division of Vital Records,	s after death s after death al Director: ad in by the	Certific		28e. Place of Injury - At hom building, etc. (Specify)							
Divis	ospital or Attendent hours after death uneral Director: ly filled in by the	cai Certification;	4 Homicide determined	building, etc. (Specify)	edge, death	occurred at the time, date and	place, and	d due to the cal	use(s) and r	nanner as	stated.
Divis	in 8 Hospital or Attent in 24 hours after death the Funeral Director: ipletely filled in by the	edical	4 Homicide determined 29a. Certifier (Check only one) Check only one) determined Certifying Ph 2 Medical Exam	building, etc. (Specify)	edge, death n and/or inv	estigation, in my opinion, death	place, and	at the time, da	te and place	, and due	to the cause(s)
Divis	or Attenuater death	Medical Certific	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) ysician: To the best of my knowledge. inner: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, in my opinion, death 29c. License number	occurred	at the time, da	te and place	e, and due	to the cause(s)
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Divis	To the Hospital or Attent within 24 hours after dealt to the Funeral Director.	edical	29a. Certifier (Check only one) 29b. Signature and title of certifier P. V. Name and address of person who	ysician: To the best of my knowledger. On the basis of examination and manner stated.	n and/or inv	29c. License number Dob657	·33	at the time, da	te and place d. Date sign	e, and due	Day, Year)
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Divis	To the Hospital or Attent within 24 hours after death to the Funeral Director.	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier P. V. Name and address of person who one	ysician: To the best of my knowledger. On the basis of examination and manner stated.	an and/or inv	29c. License number D 0 6 6 5 7 Print)	·33	at the time, da	te and place d. Date sign	e, and due	Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Margaret Lacey
4a. Facility Name (If not institution, give street and number MARCH 11:30 PM 28 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Bulk muce
If Under 1 Year | If Under 24 Hrs. | Hours | Min. DECUMER 5. Social Security Number 8. Date of Birth (Month, Day, 5-2-1942 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months 294-36-3275 65 Alabama Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 14 Yes 2 No Director n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 1811 N. Smilwood Street 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 Ñ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No SpeAfrican-American 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Linens of the week Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Horton Carrie D. Varnon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If item 27 is any injury or other trauonce. 3305 Smith Avanue Pikesville, MD 21208 Teresa Bailey / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥☐ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 4-4-08 Woodlawn, MD 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 ent. The rithe disease, or prodications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) **Physician** Atminoscienone /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it among the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NA/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Ja RI EUE 31. Date filed (Month, Day, Year)

APR 0 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

29c. License number

BR7794832

29d. Date signed (Month, Day, Year)

BaltineRE Street Belline RE, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** P^{M} March 25, 2008 4:56 BETTY LYLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🏻 F 80 213-24-5526 7-6-1927 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No N/A BALTIMORE Director MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2339 MONTEBELLO TERRACE 21214 Funeral 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □Mo Specify: BLACK 2 3 ☑ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY -12--4-TEACHER: 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be HELEN GILMORE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5016 MORELLO RD. BALTIMORE, MARYLAND 21214 MICHAEL DELLE SR. (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date/ 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3-29-2008 5 Other (Specify) METRO CREMATORY BALTIMORE, MARYLAND 4 □ Donation HIBNER Name and Address of Facility REDD FUNERAL SERVICE uneral Sec ic Licensee ONATHAN 21. Signa 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she for heart failure. List only one cause on each line.

Immedia Cause (Final disease to condition resulting in death)

a. Due to (or as a consequence of the condition of **Physician** 6 KOUrs /Medical Due to (or as consequence of): pneumonia Examiner hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1□ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. D52197 3-26-2008

State Registrar

31. Date filed (Month, Day, Year)

REKHA

6701 N. CHARLES ST. BALTIMORE, MD 21204 MOTAGI GB MC 32. pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** egins 27 /Medical Name (If not institution, give steet and number) 4b. City, Town 4c. County of Deal Examiner 7. Age (In yrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Min. 1 M 2 X Months Hours Director 13 1930 ma Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1. Ces 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21 10 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 22 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College, (1-4or 5+) HOME 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harnson skee n 19m 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Ce celia SISIE Bacto Virginia mdi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State -2-08 Cemetery 🏂 🗆 Other (Specify) 4 □ Donation. 0 21229 md. 23a. Palti. Exercise is shock, ir sant faild Immediate is se (Final r ne Isease, or complications the art failure. List only one cause **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner for use as the burial-tr nsit been signed by the attending physician and should be detached for use as the burial-tree law requires that the death certificate be exec to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 this certificate has autopsy perforn 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place and place, and due to the cause(s) and manner as stated. 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and add

Registrar

DHMH 17 Rev 1/2001

State

31. Date

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend item 26 per doc 9878 4-2-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 29 CAROL MARCH GAIL LURIE 2008 7:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5701 ENGLISH COURT BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 08/01/1946 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F Months Hours Min. 212-48-7073 Director 61 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 1 ☐ Yes 2 No Director SARASOTA **VENICE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 ALHAMBRA ROAD, #304E 34285 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE þ Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) EXECUTIVE ASSISTANT AT&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISAAC BERMAN ROLL JEAN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARVIN LURIE / HUSBAND 627 ALHAMBRA ROAD, #304E, VENICE, FL 34285 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State BENEFICIAL CIRLCE 1 X Burial 2 □ Cremation 3 □ Removal from State 03/30/2008 4 Donation 5 Dother (Specify) ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. umin 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepato cellular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s autopsy performed: To the Hospital or Attending Physician: this certific ral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) daughter's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aresidence 6 Nother (Specify) residence 1 Yes 2 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a...
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5. Wilks 00063195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 old George town Bethesda , MD 20214 Steven Wilks mb

State Registrar 31. Date filed (Month, Day, Year)

APR 02

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()

			1 - State Registrar		,	Cert	ificate of	Death	•	Reg. N	_ U U U	, 0010
	Dhomini		1. Decedent's Name (First, Middle, Las	st)					2. Date of D Month	Da	ly Yeer	3. Time of Death
ш	Physici /Medic		Dorothy	Μ.	Lesni	ewsk	i		March	1 28	,2008	10:45A [™]
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of I	Death	40	County of Death	
			Riverview Care				Essex	1 1/11-1-04			Baltimo	
	Funeral Director		217-07-6425	ex 7. Age □M 2 □XF	81		If Under 1 Year Months Days	If Under 24 Hours	Min. B. Date of B. (Month, D. Dec 1	$\frac{1}{2}$, $\frac{1}{2}$	26 Mary	place (State or Foreign ntry) Land
	and *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loca	ation					10d. Inside City Limits
	Aaryli sho	5	,									1⊠Yes 2 No
	the t	Director	Md .		D	arti	more C	114		10a. C	itizen of What Cou	ntrv?
	with Sa or		268 South Dunc	an Stree	· †		212	31			.S.A.	, ,
	death ms 2;	Funerai	11. Marital Status	12. Was Decedent B		13. W	1		n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ameri	
5-0036	be filed within 72 hours after death with the Maryland at Hygiene. An Hygiene de other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. The Medical Examiner must be notified at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 X N If Yes, Give Year or Dates:	lo	i	Yes, specify Cuba ⊇Yes 2,7∑No	an, Mexican, F Specify:	Puerto Rican, etc.)		Black, White, Specify: Whi	
က်	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a	a. Decede	nt's Usual Occup	ation during most o	f working	16b. I	Kind of Business/Ir	ndustry
Maryland 2121	within 72 ene. than "nat	igh.	Elementary/Secondary (0-12)	College (1-4or 5	+)		nd of work done O NOT use retired	1)				
2	filed w Hygier other ti		8th 17. Father's Name (First, Middle, Last)			Lab	orer	19 Mothor's	Name (First, Middl		anning	
anc	ould be filed v Mental Hygie barked other t netic event, II	Be	Antoni Lesnie	_					phine Ma			
2	2 should be and Mental is marked of aumetic ev	၉	19a. Informant's Name/Relationship (7		10	h Mailing	Address (Street		or Rural Route Num			n Code)
<u>N</u>	s 1 and 2 should f Health and Mer ltem 27 is marke other traumetic		Stephen J. Les									
altimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 tit any injury or other tra once.		20a. Method of Disposition		20b. Place o	of Disposi	tion (Name of atory or other place	ce)	Date	20c. I	ocation - City or T	own, State
Ē	Page nent c int: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify						-31-2008	Ba1	timore,	Maryland
aII	mit. porta y inju		21. Signature of Funeral Service Licen	998		22.	Name and Addre	ss of Facili	aczorows	ski	Funeral	Home, PA
m	88 5 6 8		Permit / Zu	day		12	201 Dun	dalk	Ave. Bal	Ltim	ore,Md.	21222
П			23a. Part1. Enter the disease or comp shock, or heart failure. List only	olications that caused one cause on each lir	the death. Do	not enter	the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Acw	ار (د	200	ici	Avv	inne			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence							
	Cadimilei	_	Sequentially list conditions,	b	onony	1	cutery	di	ecile			
	₹ W &	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequencé		(1)	. 1				
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as:	consequence	a of):		vumb	Cari			
09	be e sician buria			C	2 ure	0	hund	2/				
68760	ficate physics fine	Medical	`	d	5							
X	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deliv	very
ň	w requires that the death co been signed by the attend should be detached for us	by Physician	in the past 12 months? 1 □ Yes 2 X No	1□Live birth 4□Pregnant at			ctopic pregnancy Other <i>(specify)</i>	<u> </u>			Month	Day Year
O.	t the by the	hys	9 Unknown	9 Unknown								
Records, P.O	as tha gned se de	by P	Part II. Other significant conditions of		ut not resulting	in the und	lerlying cause giv	en in Part I.	23e. Dio	l tobacco		the cause of death?
or d	equire en si ould b	ed	Advance	d de	men.	na.			1	Yes :	2 □ No 3 □ Pro	bably 4 Ninknown
ecc	has be	Completed							24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
		E O							per 1 ☐ Yes	formed?	death? o 1 ☐ Yes	
Vital	ysicien: The lis certificate ha	Be (25. Was case referred to medical examiner?						f Death (Check only	one)		
7	Physic this candire	P	1 ☐ Yes 2 ZNo	Hospital: 1 ☐ Inpatie			3□ DOA Cth	4 Danuis	ing Home 5 Re			ify)
Ē	ing P	 0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y <i>Year)</i> 28b.	Time of Injury	28c. Injur Wor		28d. Describe	how inj	ury occurred	
Sic	ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be		una. At hama d	form stro		Yes 2 No		(Stroot o	and Number or Rui	m I Pouto Number
Division of	after Direction by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	idiiii, Stiei	et, factory, office		City or T			ar riodio rearribor,
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funarel Director: After this certification to the Funarel Director: After this certification is a second to the funeral director, the funeral director, completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledd	ge, death	occurred at the tir	ne, date and	place, and due to th	e causeí	s) and manner as	stated.
	ne Ho	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination a	ind/or inve	stigation, in my o	pinion, death	occurred at the time	, date a	nd place, and due	to the cause(s)
	To the withing To the Comp	M	29b. Signature and little of certifier		_		29c. Licens				ate signed (Month	
) Open	- 4	. 0		20	0221	. ,		03/30/	
	١		30. Name and address of person who	* 1	-	rea .			0		x 2/2	
	}		30000	1.50		aste	vn An	enne	Balt	mo	x 212	14
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Tonak	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 20b, 26 per in/dr., 28/8, 04/02/08dhb Registrar Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** H. McMoms Israel 03 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Batto 4018 Eierman Ave Mr 9. Birthplace (State of F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐ F 238-30-8502 86 4.22.1923 Director Usual Residence of Deceden 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Baltimore M Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) U.S.A 4018 Eierman Avenue Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify. à Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hyglene. Important: if tem 27 Is marked other than ", any Injury or other traumatic event, the Mec once. Elementary/Secondary (0-12) College (1-4or 5+) Ice Company 10th ngineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Joe McMaris ဥ Mae Heuderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Geraldina McMorris 4018 Eierman Avenue Baltimore MD 2/206 ace of Disposition (Name of 200 Date on 200 Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 03/20/2008 1 ☐ Burial 2 Defemation 3 ☐Removal from State Greenmount-Crematury 22. Name and Address of Facility Vayorin C. Greene Frence Services Address of Pacility Vayorin C. Greene Frence Frence Services Address of Pacility Vayorin C. Greene Frence Frence Frence Frence Frence Frence Fr 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I censee aus 0 · 21212 23a. Part1. Enter the ars ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHF-decompensate mon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and the burial-tran Due to (or as a consequence of) physician law requires that the death certificate be Physician/Medical SS IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 9 2 No 1 Tyes 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No. 24a. Was an certificate has 1□ Yes 25 or Vital Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ZER/Outpatient 1 🗌 Yes 1 Inpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division Hospital or Attending 1 Natural 5 Pending investigation Injury 1 Tyes 2 No thin 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D0064142 rest of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

3

Gom

32. Registrar's Signature

2323 Orleans St Balto MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 10580

ry Grooms Mo		ne For State	Stat	e of Maryland	Departi Certif	ment of ficate of	neann and Death	IVICIIIAI		g. N o.				
ო Physicia		egistrar Decedent's Nam	e (First, Middle,	ast)					2. Date of Deat Month March 20,	Day Year	3. Time of Death 1340 hrs			
Examin			G. McCr							4c. County of D				
	4	a. Facility Name (i	f not institution,	give street and number)		4	b. City, Town, or	Location of De	eath	Anne Arun				
		Southbound	Route 2 Ea	ast of Jesse Road			Harwood		lo Data of Bio	1	. Birthplace (State or			
Funeral	5	. Social Security I	lumber 6	. Sex 7. Ag	je (In yrs. last	birthday)	If Under 1 Year Months Day		Min. 8. Date of Bir	IN (MIM/DD/TTTT)	oreign			
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		Jsual Residence of									10d. Inside City Limit			
any		10a, State	10b. County			own or Locati					1 Yes 2 X N			
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urylar 3a-f s at on	ま	10e. Street and Nu					10f. Zip Code	00770	[]	USA				
or 2	Director	Box 207	Owensv	ille Road			1	20778			American Indian, Black,			
r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status		12. Was Deceder	nt Ever in U.S	. 13. Wa	is Decedent of H	spanic Origin?	(Specify Yes or No uerto Rican, etc.)	White,				
item item	Funeral	1 X Never Marr	ied 2 Ma	rried Armed Forces	2 No					Specify:	white			
fter d		3 Widowed		rced If Yes, Give Year	48-53		Yes 2X N		Lafarrada dono	16b. Kind of Busi				
urs a tura amin	황	15. Decedent's E	ducation (Spec	ify only highest grade co	·	16a. Deceder during m	nt's Usual Occupa nost of working life	ation (Give kinder. e. DO NOT us	e retired)	TOD: Name of Busin	,			
n "na	Completed	Elementary/Sec	condary (0-12)	College (1-4 o						educat	ion			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	п	12			5+	tea	acher	18 Mother's	Name (First, Middle,		1011			
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Ŝ	17. Father's Name							na Beste					
21 be fil mtal J	Be	Richard	Byron	McCrone Sr		10b Mailin	no Address (Str.		er or Rural Route Nu	mber, City or Town	, State, Zip Code)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	유	19a. Informant's I							Edgewater		37			
Baltimore, MD bernit. Pages 1 and 2 shc Department of Health and Important: If item 27 is injury or other traumatinjury or other or other traumatinjury or other traumatinjury or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or				ton/sister	120b. P		sition (Name of		Date	20c. Location -	City or Town, State			
re, s I an f Hea f iter		20a. Method of D		3 Removal from		rematory or o	ther place)							
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E Pe W	_						1timore	MD 2	1201	rrest, shock, or hea	art Approximate Inte			
ysician		23a. Part I. Enter	3a. Part I. Enter the disease, & complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artest, shock, or heart all all ure. List only one cause on each line. Between Onset and Death											
ical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
LAdillille		or condition resu	ilting in death)	Due to (or as a co	nsequence of	т):								
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ords, P.O. Box 68760, aw requires that the death certificate be exmans been signed by the attending physician chemical he detached for use as the burial.	Me	IF FEMALE: 23b. Was deceded	ent pregnant in	23c. If yes, ou			Fetal death	3 Ectopic	pregnancy	Month	Day Year			
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the de	Physic	Part II. Other si	gnificant cond	itions contributing to c	leath but not	resulting in th	e underlying cau	se given in Pa			ribute to the cause of death			
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Division of Vital Records, tal or Attending Physician: The law require rs after death. The Thirt is a floor this certificate has been sind to be a second t	Completed						26.0	loss of Doath	(Check only one)	2 110				
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on of lending Pheath.	- L			28a. Date o (Month, Mar 20, 2	if Injury Day Yaar) 2008	1329 hrs	******	Yes 2	Driver au	ito auto collisio	on			
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/iSi		3 Suicide	6 🗌 Cd	ould not be 28e. Place			street, factory, of	nce building, e			of Jesse Road, Harwoo			
ital Division at D	ortific	4 Homic	de	termined (Specify)	Local Str	eet								
			Certifying	Physician: To the best	of my knowle	edge, death o	courred at the tin	ne, date and pl pinion, death o	ace, and due to the ccurred at the time.	date and place, and	due to the cause(s)			
thin ;	Completely	, , , , , , , , , , , , , , , , , , ,		and mariner st	r examination ated.	and/or mives				29d. Date sid	gned (Month, Day, Year)			
T ≥ T	20	29b. Signature	and title of cert	ifier				icense number	•	March 21				
		1	v. 0 9	1020 M	6		').C.M.E.		Wat Off 2				
		30. Name and	address of pers	on who completed caus	e of death (Ite	em 23a)			N.D. 01001					
			Greenberg M		edical Exa	miner 1	11 Penn Str	eet, Baltim	ore, MD 21201					
	Sta				gistrar's Sign	ature	Annak 1							
Rec	jistr	ar	Month, Day, Ye.		A But	1850 St.	S. C. Carlotte State of the Sta							
				OCME		OPIC								

State Registrar one)

29b. Signature auto

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2008 2

Steven tu l'Er 31. Date filed (Month, Day, Year)

Road, Randalls bury

29d. Date signed (Month, Day, Year)

and manner stated.

on who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

(out

08-02345 Gilbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10582

ert Nac	dolny	1	- For State	State	of Marylar	Ceri	tificate of	Death	Q 11121111	, 5	Reg.	No		
Di		R		ne (First, Middle,Las	it)					1.4	ate of Death	av Year		ime of Death
	iysicia Examir	-	GILB	ERT J. NA	DOLNY					Ma	arch 24, 20	4c. County of I		7 -10 1110
				(if not institution, giv		ber)		4b. City, Town, or Sparrows F		Death		Baltimore		
			2901 Delma	ar Avenue						24Hrs 8 1	Date of Birth			ice (State or Foreign
Fu	neral		Social Security I			Age (In yrs. Ia		If Under 1 Yes				, 1941	Country	MD.
Dir	ector	H	219-40-	0208 12	M 2 F	67	Yrs	5.			ED. I.	, 1541		
		-	Usual Residence			Inc. City	Town or Loca	tion						d. Inside City Limits
	v any	- 1	10a. State MD •	10b. County BALTIMO)DF		EDGEME						1	Yes 2 X No
land	f sho	5						10f. Zip Code				. Citizen of Wha		
Магу	s 23n or 28n-f show a e notified at once.	Director	10e. Street and No		7				2	1219	Ul	NITED ST	ATES	
th the	23a o notifi		11. Marital Status	ELMAR AVI	12 Was Dece	edent Ever in U	.S. 13. W	as Decedent of H	ispanic Origi	in? (Specify	y Yes or No-	14. Race - White,		Indian, Black,
ath wi	tents	Funeral		ried 2 XMarrie	Armed Fo	rces?	If	Yes, specify Cub	an, Mexican,	Puerto Rica	an, etc.)		WHIT	E
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	Hygical other	ပိ		ne (First, Middle, Las I NADOLNY	st)				GEN	EVIEVI	E BARO	N		
2121 ould be f	fental arke	o Be		Name/Relationship	(Type, Print)		19b. Mail	ing Address (St	reet and Nun	nber or Rura	al Route Num	ber, City or Tow	n, State, Z	(ip Code)
D 2	and N 7 is n natic	ř		A NADOLN				1 DELMAI				MARYLAI 20c. Location -		21219
≥ and 2	lealth tem 2 traur		20a Method of D	Disposition			Place of Disp crematory or	osition (Name of other place)	cemetery,		Pate			
OFE	t of H			2 X Cremation		rom State	METRO C	REMATRO	Y	3/26	/2008	BALTI	MORE,	MARYLAND
Baltimore, MD	popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		4 Donation	5 Other Spec Funeral Service Lic	ensee		22	. Name and Addr	ess of Facilit	y CHA	RLES S	ZEILE	R & S	SON, INC.
Ba	Depa Inju		V	1 /	6 4.10			6224 EA	STERN	AVE.,	BALTI	MORE, M	AKYLF	AND 21224 Approximate Interval
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o,	that the death certificate be ex- ned by the attending physician detached for use as the burial	ipa	IF FEMALE:		23c. If yes	, outcome of pr	regnancy					23d. Date of		ay Year
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200	law re has be 7 sho	3	<u></u>								perf 1 ✔ Yes	ormed? 2 No	death? 1 ✓ Ye	es 2 No
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可	cian: certif	6	25. Was case of examiner?	referred to medical	Hospital: 1	Inpatient 2	ER/Outpa	itient 3 DO	Other ₄		Home 5	Residence 6		r: Scene
Ę	ling Physician: After this certifi	B	1 ✓ Yes 27. Manner of		28a. Da	ate of Injury		e of Injury 280	. Injury at W		28d. Describ	e how injury occ	urred	
ā	h A : Aft		1 V Natura	al 5 Pend	ing	onth, Day, Year)			Yes 2					
isio	Attend er death rector:	ny un	2 Accide		tigation 28e. P	lace of Injury -	At home, farm,	street, factory, o	ffice building	, etc.	28f. Location or Town	(Street and Nur , State)	nber or Ri	ural Route Number, Cit
Division of Vital Records,	tal or rs afte ral Di	Illied III	1 Natura 2 Accide 3 Suicide 4 Homic	deter	mined (Spec	ify)				1				
7	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and The first of the Library of the chiractory man 2 chould be detached for use as the burial - transit			Certifying Ph	nysician: To the	best of my know	wledge, death	occurred at the ti	me, date and	place, and occurred a	due to the ca it the time, da	use(s) and man te and place, an	ner as sta d due to t	teul. he cause(s)
	the ithin 2	completely	91	Medical Exam	miner: On the bas and mann	sis of examinati	on and/or inve	stigation, in my o	License num					onth, Day, Year)
	Ĭ ŭ Ĭ	8 8	29b. Signature	e and title of certifie	er			l	O.C.M.E.			March 2		
	,		a	-58m					vi.∟.			1		
	4	1		address of person	who completed	cause of death	(Item 23a)	nn Street, Ba	altimore. N	MD 2120	1			
	J				sistant Medic	200		an Ottoet, De			. — —			
		Sta	te 31. Date filed	(Month, Day, Year)	2 2008 32	. Registrar's Si	griatule	DOBALL						

		1- State amend #8 Per	State of Maryla Ana BD G878	nd / Depa 4/02/98	artment of	Health and Death	Mental Hy	giene,	2008	10	583
	ш	1. Decedent's Name (First, Middle, Last)					2 Date of De	ath		3. Time	of Death
Physic /Med		James F. O'Donne	11				March	11,	2008 ^{Year}	3:00	РМ м
Exami		4a. Facility Name (If not institution, give s				or Location of De	ath		County of Death	1	
		6200 Foreland Ga		- to a bird of . A	Columbi		(C 0 D (D)		loward		
Funera Director		5. Social Security Number 6. Sex 226-367478		s. last birthday) Yrs.	Months Days		n. (Month, Da	y, Year	9. Birth Cou	piace (State intry) vland	or Foreign
ō		Usual Residence of Decedent					July 22	., 17.	Z7 Mar	yrand	
arylar show	_	10a. State 10b. County		City, Town or Lo	cation					10d. Inside	•
he M.	Director	MD Howard	C	olumbia	1			48 011			s 2√ No
with a		10e. Street and Number 6200 Foreland Gar	a+h		10f. Zip Code	210/5		10g. Citize	en of What Cou	intry?	
death	Funeral		2. Was Decedent Ever in	U.S. 13.1	Was Decedent of	21045 Hispanic Origin?)- 1·	USA 4. Race - Amer	ican Indian,	
or ite	Ξ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				(Specify Yes or No erto Rican, etc.)		Black, White		
ours irel',	d by	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	o Specify:		3	Specify: W	nite	
within 72 hours elter death with the Maryland ane. ane. then "naturel", or iteme 23a or 28a-f show he Medical Examinal must be notilised at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occi kind of work don- DO NOT use retir	e during most of w	vorking	16b. Kin	d of Business/la	ndustry	unk
withig ene. then	d E	Elementary/Secondary (0-12)	College (1-4or 5+)	me.							
Definition of the proof of the	Be Co	17. Father's Name (First, Middle, Last)			dispato		lame (First, Middle	, Maiden S	Sumame)		
Aenta Aenta rked	To B	John Carroll 0'	Donnell			Mo	llie Mary	Alle	en		
2 should be filed v and Mental Hygie ie marked other raumatic event. It	1	19a. Informant's Name/Relationship (Typ	· · · · · · · · · · · · · · · · · · ·				Rural Route Numb			ip Code)	
and and m 27		Flora Trail/sist		- Victoria - Control		Rivers I	Road Colu			L044	
permit. Pages 1 and 2 should I Department of Heelth and Men Importent: if item 27 ie marke any njury or other traumatic.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		. Place of Dispo cemetery, crer	sition (Name of natory or other pi	ace)	Date	20c. Loc	ation - City or T	Town, State	
t. Pa rtmen rtent:		4 ☑Donation 5 ☐ Other (Specify)	11	1		1					
Dep		21. Signature of Emperal Service License ROTTAL	ad Wirecto				rd 655 W.	Balt	timore :	Street	:
_	-	23a. Part1. Enter the disease, or comblished shock or heart failure. List only on	allions that caused the de	ath. Do not ent	1timore er the mode of ch	MD 21:	201 iac or respiratory a	rrest.		Approxim	ate
Physician		Immediate Cause (Final				1.1-				Interval B Onset and	
- /Medical		disease or condition resulting in death)	Corona? Due to (or as a conse	ry an	tery	asse	ase			5	42
Examiner		Committee the first source that the	Hyper Due to (or as a const	-tens	ion					0.00	123
₽ #	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying									·
ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Puntofassassassassassassassassassassassassass	x + 21 1	Tree	rdeni	a.			21	125
ate be executed hysicien and the burial-transit			Hypes Due to (as a conse Carot	id a	110	di	1000			921	121
tificate ng phys as the	edicai	_ d		, , , ,			- oen			/	, ,
ndir use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of preg		<u> </u>			2:	3d. Date of deli	very	
death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown		Ectopic pregnan Other (specify)	cy			Month	Day	Year
net the de d by the e	Phys	9 🗆 Unknown									
		Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause g	given in Part I.			se contribute to		
w require been si	Completed						- 10	Yes 2	JNo 3∐Pro	bably 4	Unknown
The law sie has boage 2 st	gu						24a. Was		24b. Were aut prior to c death?	topsy finding completion of	s available cause of
ician: The L certificete ha	e Co	OF Management and the market					1□ Yes	2 X No	1 ☐ Yes	2 No	
or Attending Physician: The law requires the law requires the faller deeth. Director: After this certificete has been signed in by the funeral director, page 2 should be considered.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	□ EB/Outpation	t 3 DOA		Death Check only		COther (Case		
g Physer this		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			any)	
eth. reth. r: After	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 19al)	Injury		onk? ⊒Yes 2⊡No					
r Atter de lirecte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe-	home, farm, str	eet, factory, office	9		Street and wn, State)	Number or Ru	ral Route Nu	ımber,
urs af urs af iled ir			1								
To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifict completely filled in by the funeral director.	edicai	29a. Certifier 1 Cartifying Phys (Check only 2 Medical Examin	ician: To the best of my k ler: On the basis of exami and manner stated.	nowledge, deati nation and/or in	n occurred at the vestigation, in my	time, date and pla opinion, death or	ace, and due to the ccurred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause	e(s)
o the ithin (o the omple	Med				29c. Licei	nse number		29d. Date	signed (Month	n, Day, Year)
⊢≯⊢ŏ		> Christa v	~D		D	34970	4	ma.	rch 2	15/20	08
		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print)	+ 4 2 2 /	colus	nhìo	aMn	2 101) , ,
		30. Name and address of person who con CHARUMEHTA, MEHTA, M	1D 8775 cl	ond (resp -	1 4 6 6 9	1		·, · · · ·	2100	T2
	tate	31. Date liled (Month, Day, Year)	32. Pagistrar's Sig	nature	10						
Regis	trar	Ark U & 2l	UO STEELS	المحار المائد							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ann 27,2008 trances Parker Marc /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ical entel La 160 If Under 24 Hrs. If Under Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 KF Hours 65 Director Washington DC Decomber 3, 1942 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Charles Maryland Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or Garner Avenue 527 USA 20602 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. I □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CAShier Unknown Server Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frazier ၉ Harvey Annie TUTNET Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parker Garner Avenue Waldorf IM, Virg. 1 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 □ Removal from State Anatomy Gifts Registry March 29,2008 4 Monation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lip 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P. MO 31076 23a. Part . Enter the disease, or complications that has the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending phase as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performen?
Yes 2 No the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed [Month, Dav. Year) who completed cause of death (Item 23a) (Type, Print) APR 02 Day, Year) 32 Registrar's Signature State 2008 Registrar

		Pleas State Registrar			d / Depa		lealth an	d Mental Hyg	giene	0 8	10585
Physici /Medio	cal	Decedent's Name (First, Middle Thomas Frankli Aa. Facility Name (If not institution	n Pinder	nber)		4b. City, Town, o	r Location of D	2. Date of Dea Month March			3. Time of Death
Examili	iei	8644 Camp Rd.				,,,	Cheste	ertown	Kent		
Funeral Director		5. Social Security Number 215-36-0387 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 69	last birthday) Yrs.	If Under 1 Year Months Days	Hours 1		71939	9. Birthp	place (State or Foreign htry)
yland now at		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
ne Mar 8a-f sk ptified	Director	MD Kent		Ch	estert						1 ☐ Yes 2 Mo
with the		10e. Street and Number 8644 Camp Rd.				10f. Zip Code 21620	_		10g. Citizen of V United		•
death	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin'	? (Specify Yes or No Puerto Rican, etc.)	14. Rac	e - Americ	can indian,
72 hours after death with the Maryland 72 hours after death with the Maryland inatural", or items 23a or 28a-f show dical Examiner must be notified at	þ	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced		2 No		1 ☐ Yes 2 ☑ No	Specify:	2010 1 110321, 0131,	Specify	Whi	te
hin 72 h	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1	-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of d)		16b. Kind of Bu		
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yianing ould be fil Mental H arked otl attic even	To Be	17. Father's Name (First, Middle, Earl Hopkins P	inder				Emma	Name (First, Middle, Caroline K	night		
and 2 shealth and 2 27 is mer traum		19a. Informant's Name/Relationsh Kay B. Pinder/V						tertown,			Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S)		State	cemetery, cre	osition (Name of matory or other placed Service		Mar 25 2008	20c. Location - Bethes		own, State [aryland
permit. Departmit. Importa		21. Signature of Funeral Service	licensee	M00382	2	Name and Addre Rapp Fune 933 Gist	ral & C Ave. S	remation Se	ervices	Land 2	20910-
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	_a. A	aused the deat ach line. JLMONAI (or as a conseq	RY FIE		ng, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	icome pf pregn birth 2 Feta nant at time of c own	al death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у	1		te of deliv	ery Day Year
quires tha	b	Part II. Other significant condition	ons contributing to de LORONARY		•	, ,	ven in Part I.		obacco use cont Yes 2□ No	3 Pro	he cause of death? bably 4 Unknown
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ysiciai ysiciai s certii	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Ott	or:	Death (Check only only only only only only only only		ner (Speci	ful
riding Phy th. r: After thi e funeral o		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date (Mon		28b. Time o	of 28c. Inju		28d. Describe	how injury occur		97
a or Atte	Sertification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined Zee. Place	of injury - At h		reet, factory, office		28f. Location (City or To		oer or Run	al Route Number,
ne Hospit 24 hours ne Funera	Medical C		Examiner: On the b					place, and due to the occurred at the time,			
To the within To the To the Comp.	M	29b. Signature and title of certifier	ddaloxi	20		29c. Licens		3 - mo	29d. Date signe	ed (Month, 25/01	Day, Year)
20		30. Name address of person	h HII Rd	Juite ?	00 CI		MO ZI	620	7	1	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 2	2008	Registrar's Sign	ature	whi					

DHMH 17 Rev 1/2001

2008 10586 Barbara J Pergerson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month 0249 hrs March 26, 2008 **Medical Examiner** Barbara J. Pergerson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Cou**Mra**ryland Months Days Hours Min. Director Mar 7 1947 219-54-4948 1 M 2 X F 61 Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Y Yes 2 No Anne Arundel Annapolis Maryland 28a-f show narked other than "natural", or Items 23a or 28a-f sho event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 24 Bens Dr. Apt E 21403 莅 Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: Black within 72 hours after 3 Widowed If Yes, Give Year Yes 2 X No specify: Divorced <u>۾</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Anne Arundel Co. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12th Custodian Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages I and 2 should be filed on the filed of Health and Mental Hyg Joseph H. Pergerson Sarah Smothers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is m r traumatic 24 Bens Dr. Apt E Annapolis, Md. Tyra Harris(Daughter) 21403 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Saltimore, other t 1 X Burial 2 Cremation 3 Removal from State Memorial Park 4-2-08 Annapolis, Md. Important: injury or oth 4 Donation 5 Other Specify: 2 Name a Books of Famility Ons or uary, . . . 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Varry 1. Teese MO0483 2a. Part I. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, Pt.II, 27 per ME g878 4/8/08 amh X UNPENDED attending physician or use as the burial -Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ signed by be detach 2 Yes 2 No 3 Probably 4 ✔ Unknown Chronic Lung Disease Morbid Obesity Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? Yes 2 ✔ No 2 No Yes certificate Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Other: DOA Nursing Home 5 Residence 6 Others this 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural Director: 1 Yes 2 No Pending 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) determined To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 26, 2008 O.C.M.E. 30. Name Ind address of Jerson who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Melissa 2...

31. Date filed (Month, Day, Year)

A DR 0 2 gistrar's Signatur State 2008 APR 0 EPAR. Registrar

DHMH 17 Rev 1/2001

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10e per fh 9878 4-2-08 vt.
State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month SADIF 45 AM PAGE March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTON GARDENS OF PIKESVILLE PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Hours 09/10/1906 212-34-5523 101 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director BALTIMORE BALTIMORE 198400 and Number 8911 REISTERSTOWN ROAD 10f. Zip Code 10g. Citizen of What Country? 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MENDELL YAVITZ SARAH of Health and Menta item 27 is marked MALKEN ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3011 FALLSTAFF ROAD, UNIT 505, BALTIMORE,MD 21209 BARBARA LEVIN / DAUGHTER 20b. Place of Disposition (Name of BETHER) crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ABurial 2 □ Cremation 3 □ Removal from State 04/01/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Party show Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Immediale Cause (Final Physician disease or condition resulting in death) CHNCER weeks rancreatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an funeral director, page 2: 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 Accident death. within 24 hours after deal To the Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 31, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old 4000 Rothschil CONT 31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 02 Registrar 2008

within 24 hours a Hospital

> State Registrar DHMH 17 Rev 1/2001

MELITO 31. Date filed (Month, Day, Year) APR 0 2 2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. WRES, MO 441 S. ELLWOOD AVE, BALTIMORE, MO 21224 WARES, MO 32 Registrar's Signature

29c. License number 20011150

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE EASONS Randallstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11/6/1931 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 579-48-3252 76 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 XYes 2 No Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7319 Elmore Avenue 21244-2866 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Carpet Installer Flooring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Rhubottom Mary Griffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Wrightson/Person.Rep. 624 E. 38th Street Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem Gds 4/3/2008 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Hubbard Funeral Home, Inc. Made T. 7 4107 Wilkens Avenue Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) FIB if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last are different tell utleftmann Due to (or as a consequence of) Due to (of as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed'

Physician /Medical Examiner

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page 2

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Physician

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Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygene.

ant: If ten 27 is marked other than "natural", or items 23a ant: If ten traumatic event, the Medicial Examiner must any or other traumatic event, the Medicial Examiner must.

permit. Pages 1 Department of H Important: If Ite any injury or ot

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

To the Hospital within 24 hours a

with the Maryland r 28a-f show notified at

> Examiner Physician/Medical

Completed by Be Certification: To

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

2 No 26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 Yes 2 No
To Zano
27. Manper of Death

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural
2 Accident

3 ☐ Suicide

4 ☐ Homicide

Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6426

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item) 23a) (Type, Print) ton

31. Date filed (Month, Day, APR 0 2008

W. Registrar's Signature Swite 212A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 29, Day 2008 ear **Physician** Mary E. Roya1 11:45а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Rockville Montgomery 8. Date of Birth (Month, Day, Year) 01/19/1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 □ M 2X F 73 192-28-3358 Yrs Director PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show ral", or Items 23a or 28a-f shor Examiner must be notified at MD Montgomery Silver Spring 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 North Leisure World Blvd. 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within lealth and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 5+ LPN Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis N. Katie Veno1a Hawkins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Health item 27 Daniel Royal / Husband 3330 North Leisure World Blvd., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of He important: If iter any injury or oth 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Homewood Cemetery 4/05/2008 Pittsburgh, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transi attending physician and for use as the bunal-trar resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the at d be detached for 4☐Pregnant at time of death P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 autopsy 2 **X** No 1□ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4\square \, \text{Nursing Home}}$ 5 $\square \, \text{Residence}$ 6 $\square \, \text{Other} \, (\textit{Specify})$ Hospice 1 Yes 2X No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After to completely filled in by the funera

State

31. Date filed (Month, Day, Year)

and title of certifier

Dec

29a. Certifier

29b. Signat

Medical

Montgomery Hospice 6001 Muncaster Mill Road, Rockville, MD 20855 32. Redistrar's Signature

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ne and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 0064615

29d. Date signed (Month, Day, Year)

March 30, 2008

1. Decedent's Name (First, Middle, Last)

Certificate of Death

Day

3. Time of Death

2. Date of Death

Physician
/Medical
Examiner

11:35 P.M. Margaret C. Roberts 12 2008 March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Timonium

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Stella Maris Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√E F 70 May 30 1934 MD Director 213-30-9912 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. 9m 27 is marked other than "natural", or items 23a or 28a-f ehow 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2√ No Director MD Timonium Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or be 21093 2300 Dulaney Valley Rd. USA Pages 1 and 2 should be modern that the modern of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or items 23a item, or other traumatic event, the Medical Examiner must item. Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josie S. Benson Robert A. Fishpaw ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30 Ensor Ave., Cockeysville, MD 21030 Kevin W. Roberts/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Department o Important: If any Injury or 4 Donation 5 Other (Specify)
21 Signature of Fulf at Service Licensess

Bryan W. Clary 3/14/08 Metro Crematory Catonsville, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd.. Timonium, MD_21093 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause in each line. Atheroscleretic Vascular Disease Immediat Cause Final disease or inion resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu · death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wel a. Mon. 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 114 Business Ctr. Drive, Reisterstown, MD 21136 Robert Moss, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 98/8 4-2-08 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Rosenzweig Alvin 2. Date of Death 3 Time of Death **Physician** (650 M March 2008 LW /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Baltimire Baltomore City Hospital N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Months 1 X M 2 □ F 219-14-0414 Director 82 01/18/1926 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6350 RED CEDAR PLACE, APT. 208 21209 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL ROSENZWEIG MARY MOSES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 19a. Informant's Name/Relationship (Type. Print) PHYLLIS ROSENZWEIG / WIFE 6350 RED CEDAR PLACE, APT. 208, BALTIMORE, MD 20b. Place of Disposition (Name of cemetary ergreeps or other place)
CHIZUK AMUNO 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/01/2008 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) ocardial **Physician** week /Medical Due to (or as a consequence of **Examiner** 7 2901 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine COronaries Isch Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Brandon 0520/19 31. Date filed (Month, Day, Year) State APR 02 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23h are Departagen of Fearth and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GLORIA ROSEN MARCH 2008 11:35A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6391 ROWENBERRY DRIVE ELKRIDGE HOWARD Date of Birth (Month, Day, Year) 10/03/1922 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 263-28-8238 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan in at the notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No HOWARD ELKRIDGE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6391 ROWENBERRY DRIVE Funeral 21075 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No ģ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE **HERZOG** LUSTIG ROSE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN BUDISH / DAUGHTER 6201 BROKEN WING COURT, COLUMBIA, 20b. Place of Disposition (Name of cemelary, or ematery or other place)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/30/2008 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1euis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or figury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and see as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 ☐ Yes 2**X**☐No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MARCH 28 2008

State Registrar 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print)

2000

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Drilvin to Rev 1/2001

Vernon Baker Stic			ate of Mar	yland / [and	Menta	i Hygi	ene		20	nΩ	10	59
	F	- For State tegistrar	Certifica	ate of	Death			2. D	Reg	. No.	<u> </u>	3. Time	e of Death			
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2 21 thould nd Me is ma	۵	19a. Informant's Name/Relation Joan Joyce S		wife	1								y or Town, Sta			1
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Baltimore, bermit. Pages I an Department of Hee Important: If ite		1 Burial 2 X Cremati	on 3 Remo	val from State	e crema	tory or ot h Ca	her place)	Cr	ematr	3/27	/2008		Wir	ıfiel	ld, MD	,
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OX 6	sician/Me	1 Yes 2 No 9	Inknown	Pregnant at t Unknown	ime of death	5 C	ther (Spec	ify)				2				
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Division of Vital Records, rat or Attending Physician: The law requirrs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be		25. Was case referred to med	ical			-		26.Place	of Death	(Check or						
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of \ ng Phy	n: To	27. Manner of Death	28a	. Date of Injui (Month, Day Yoar 19, 2008		b. Time o	f Injury 2		ry at Work	. In			ury occurred olved in co	ollision		
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Division 1 Hospital or Attendi 24 hours after death. Funeral Director:	Certification:	4 Homicide	11		jor Road /					-			derick Road		nck, MD	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier (Check only one) 2 Medical B	Physician: To t xaminer:On the	the best of my basis of exar	y knowledge, o mination and/o	death occ or investig	urred at the ation, in my	time, d	ate and plant n, death o	ace, and d ccurred at	the time, date	ise(s) ar e and pl	ace, and due	siated. to the cai	use(s)	
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1.1		30. Name and address of per	son who complete	ed cause of d	leath (Item 23a	a)										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 03:23 PM tra Marcl 2008 /Medical 4a. Facility Name (If not Astitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MM Baltimore NA 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F Months 48 Director 225-16-1695 December 9,1959 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 BYes 2 No Director Maryland Baltimore NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 717 Druid Park Lake Drive Apt. 911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mever Married 2 Married l ∐Yes 2**13.**No fYes, Give ∕ear or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Keeper House Keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Strahan Woodrow WILKENS ၉ Rosie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Zella Brunson WEST Cold Spring Lane BAHMOR, MD 21215 Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services April 1,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services Lama C. Hardesty M-01197 7522 Connelley Drive Suite No Hanaver MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rail **Physician** tows /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bone osteomy Chis the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnantin the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day 4□Pregnant at time of death 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 P No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 100 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) 2120 Registrar's Signature 31. Date Hed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM! 7, 8, perFH 68/8, 4/4/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 1245 PM Deborah March 31 2008 Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North WEST HOSPITAL RANDALLSTOWN BALLYMORE CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 XF Days 575/1957 50 Yrs. 215-70-0882 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 □Yes 2 No Director Baltimore Pikesville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 Ciffedge USA 21208 Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Breeder Groomer Animal CATE Department of Health and Mental Hygie Important: If item 27 Is marked other any Injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES Hungelmann Margaret O'brian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville, Road Anthony Serio 808 Cliffedge MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATUMY GIFTS REGISTRY March 31, ZOOR 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ANATOMY GIFTS REGISTRY
7522 CONNELLEY DRIVE SUITER HANOVER, MD 21076 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician TERMINAL LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Jo 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 W Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 31 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 MAIN STREET herce Debarah REISTALSTOWN MO 31. Date filed (Month, Day, 32. Registrar's Signature Year) State APR 02 al special 2008 Registra

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person wh

31. Date filed (Month, Day, Year)

STUGHT

Jacobs mo

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

ORIGINAL

Dr. Glen Burnic, MD

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

305 Hospital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar **Physician** 3/28/2008 8:40 A^{M} /Medical Carrie Margaret Strange 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8838 Meadow Heights Road Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/1/1928 Birthplace (State or Foreign Country)
 SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 🏋 🗆 F 213-26-4001 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director **Baltimore** Randallstown M) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA Completed by Funeral 8838 Meadow Heights Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 3 ☑ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Machinist Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Allen Aaron Nannie Starks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita C. Pilerim /Daughter 8838 Meadow Heights Road Randallstown, MD 21133 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 4/2/2008 Balto., MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. Of Balto. Co. wy Lie runeral Home P.

23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AIZHEIMERS **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical (F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 1/2001

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

DZ6003

How. le mi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Frank Streich da Herman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County 4h. City. Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 XM 2 □ I 85 11.11.1922 Poland Director 096.12.1061 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21228 3405 Greenway #201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Film Director Entertainment permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If tem 27 is marked other the any injury or other treasment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Streich Clara Krauser ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3405 Greenway #201, Baltimore, Lori Streich/Daughter Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State Chesapeake Crem. 03.29.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 8717 Green Pastures Dr. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician CONTO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last records, P.O. Box 68760, 4 and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1□Yes 2□No the 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2□ No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | N 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat e and title of certifier

State Registrar

Registrar APR 0 2 2008

31. Date filed (Month, Day, Year)

32 Registrar's Signature

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Mion Memorial

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:30 PM 24, 2008 J. Schwark March Dorothea /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Hospice Center Towson <u> Gilchrist</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06.02.1909 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😿 312.01.8858 98 IN Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show n and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Eventine, must be notified at 1 □ Yes 2 No Director Towson Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 21204 615 Chesnut death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Credit Rating Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Leila McVicker ၉ Albert Ballinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5909 Charlesmead Rd. Baltimore, MD 21212 of Health a item 27 is other tra Thomas E. Schwark/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If iten any Injury or oth once. 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 03.27.08 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate ha 1 □Ýes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 124 hours after death. 1 Natural 5 ☐ Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25205 N. Chules St. Balto. M. L. 202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q N. sin (6707 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Month **Physician** 9-00 P M March 2008 Michael Stats /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner n/a Sinai hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) | March 13 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∏ M 2□ F Country) 79 Director 180-22-1429 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show ner must be notified at Cockeysville 1 ☐ Yes 2X No MD Baltimore Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? stats, Michae USA 21030 300 International Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. "natura!", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 ☐ Divorced ental Hygiene.

ed other than "natura; event, the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Policeman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental H BM 27 Is marked ot ther traumatic ever Mildred Milkchulik Samuel Stats 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 Brougham Ct., Manchester, MD 21102 19a. Informant's Name/Relationship (Type. Print) Michelle L. Meyers/daughter Health a or other Department of Heal Important: If Item any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/4/08 Garrison Forest, MD MD Veterans Cem. 4 Donation 5 Other (Specify) 21. Signature A Funer I Servic, Lucin 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Bryan/W. Clary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEDSIS /Medical SERVICE AND APPROVED BY MEDICAL EXAMINE Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician at the burial Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a 9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

Year

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed

2 🖳 No

28d. Describe how injury occurred

300 International

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) March 27, 2008

1∐ Yes

26. Place of Death (Check only one)

4 ☐ Nursing Home

Other:

1 ☐ Yes

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES ODD

Assi Ital hour theme

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

2. Date of Death

Division or Vital Records, P.O. Box 68760, or Attending Physician: 1 - State Registrar

1. Decedent's Name (First, Middle, Last)

within 24 hours a

DHMH 17 Rev 1/2001

State Registrar

Be Completed by

P

Certification:

Medical

2 should

page certificate

funeral director.

Director: /

Hospital

To the

Myo Cardial

5 Pending

investigation

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jeine

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

(Check only

29a. Certifier



1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

CLIK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Infaretion

28a. Date of Injury

(Month, Day

3-2708

Hospital:

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 31, 2008 8:10pm M March Kathleen Mae Stewart /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster Birthplace (State or Foreign Country)
 NC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept 2, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2√2 F 578-22-1313 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or items 23a or 28a-f shov cirver must be notified at 1 ☐ Yes 2 X No MD Carroll Sykesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 6208 Long Meadow Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ò 1 □Yes 2 1√2 No Specify Specify: White 2 traumatic event, the Medical Evan 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Lisk Ruth Gree**ne** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6208 Long Meadow Drive Sykesville, MD 21784 Mr. Glenn R. Stewart (Son) of Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 K Burial 2 Cremation 3 □ Removal from State Wesley Freedom Cem. 4/5/2008 Sykesville, MD 4 Donation 5 □Other (Specify) 21. Signature of Funeral Service Lice HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195) M60764 Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final au de Physician mos disease or condition resulting in death) /Medical Due to (Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months 1 ☐ Yes 2 ☐ Ho Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Auer mis certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🖪 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospiu Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify 1 | Yes 2 | No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Mann eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner Aul westmuster MDZ115Z RE ATI 31. Date filed (Mach, Day, Yea) 2008 State Registrar

	•	For amend #5	Per FH	of Ma G878	aryland 4/02	I / Depa /08 ∂#/	rtment of I	lealth <i>Death</i>	and M	ental Hyوا ا	giene Reg. No. 🤈	nna	10603
Physicia	ın	1. Decedent's Name (First, Midd Patricia Ann								2. Date of Dea March)8 Year	3. Time of Death 11:00 a M
/Medic Examin		4a. Facility Name (If not institution 13331 Signal					4b. City, Town, o		of Death			inty of Deati	
Funeral Director		5. Social Security Number 092-30-3	6. Sex 1 ☐ M 2 🔀	7. Ag	e (In yrs. la 69	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birt Dec 1 1	h	9. Birti Co	hplace (State or Foreign untry) York
aryland show	_	Usual Residence of Decedent 10a. State 10b. Count				Town or Loc	cation						10d. Inside City Limits 11 Yes 2 □ No
vith the Ma t or 28a-f a	Directo	MD Mont 10e. Street and Number 13331 Signal T	gomery		Pot	comac	10f. Zip Code 20854				10g. Citizen Unite	of What Co	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was l Arme rried 1 Yes	Decedent d Forces? es 250 , Give or Dates:		1	Vas Decedent of I Yes, specify Cub	Hispanic O ean, Mexica	an, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ame Black, White ecify: Wh	rican Indian, e, etc.
Baltimore, Maryland 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural"; or any injury or other traumatic event, the Medical Exami	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12)		ge (1-4or 5	5+)	(Give life. L	ent's Usual Occu kind of work done OO NOT use retire Maker	during me	ost of worki	ing	16b. Kind o	of Business/I	Industry
be filed that Hyg	Be	17. Father's Name (First, Middle								(First, Middle,		rname)	
Maryla d 2 should th and Mer 7 is marke traumatic	P	Leon Portney 19a. Informant's Name/Relation Paul G. Stern					g Address (Stree Signal	t and Num	ber or Rura		er, City or To		
more, ages 1 an ent of Heal t: If Item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 □Removal f		ce	ace of Dispo emetery, cren	sition (Name of natory or other pla	ace)		Date	20c. Locati	ion - City or	
Baltir permit. P Departme Importan any injur	1	21. Signature of Funeral Service		-	Na	22	Cremato Name and Addr 30 Wisco	ess of Fac	ility Jos	eph Gaw	ler's	Sons	Inc.
Physician	- V	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition			d the death.	. Do not ente	er the mode of dy	ing, such a	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death 2 Years
/Medical Examiner		resulting in death)			a conseque	ence of):							
outed nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		e to (or as	a consequ	ence of):						1,0	
58760, icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	d	e to (or as	a conseque	ence of):						- A - M	
Box 6 ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1□L 4□F	ive birth	e pf pregnar 2 □ Fetal at time of de	death 3	Ectopic pregnand Other (specify)	су			23d	. Date of del Month	livery Day Year
	ρ	Part II. Other significant condi	tions contributing	to death b	out not resul	Iting in the u	nderlying cause g	iven in Par	t I.				o the cause of death? robably 4 ☑Unknown
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Or Vital Physician: The Physician: The certificate ral director, pag	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital	1 🔲 Inpati	ent 2∐E	ER/Outpatier	it 3□ DOA O	hor:		h <i>(Check only o</i> ome 5 ½ Resi]Other (Spe	ecify)
		27. Manner of Death 1 ☒ Natural 5 ☐ Pend 2 ☐ Accident inves		Date of Inju Month, Da		28b. Time of Injury	W			28d. Describe			
- 0 -	Certification:	3 ☐ Suicide 6 ☐ Couli 4 ☐ Homicide deter	mined 200. r	Place of in ouilding, e	jury - At hor tc. (Specify	me, farm, str	eet, factory, office)			Street and N wn, State)	lumber or R	ural Route Number,
To the Hospital or within 24 hours all e	edical (ing Physician: T al Examiner: On and		of examinat								
	M	29b. Signature and title of certif	ier	7_		>	29c. Licer D003.	se numbe 5045	r	1	29d. Date s larch	-	th, Day, Year) 008
10	0 60	30. Name and address of person Philip Henjum						0 01n	ey, M	ID 2083:	2		
Sta Registr		31. Date filed (Month, Day, Yea MAR 1	r)										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Year 12:07 2008 March Baby Boy Simmons 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital Johns HOFKINS Inc 8. Date of Birth (Month, Day, Ye March 3, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 2008 Days Hours 1**∑**M 2□ F Maryland 46 Usual Residence of Decedent 10c. City Town or Location 10a, State 10b. County 10d. Inside City Limits 1√∏Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 280 S. Monastery Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hone none none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Alicia Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) the Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 21. Signature of Euperal Service RONald State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 3a. P.rt1. Enter the disc se, or combined insome that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tulmonary Hypoplasia Mon ths disease or condition resulting in death) Due to (or as a consequence of Months Ascites Sequentially list conditions, if any, reduing to immediate cause. Enter Underlying Cause (Disease or injury that in it had a property or injury that in it had a property in the cause of t Due to (or as a consequence of) Tract Months Urinary that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Director

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Completed

Be

2

Examine

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the bunal-tran Physician/Medical ed by the a Completed After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

þ

Certification: To

Medical

Division or Vital Records, P.O. Box 68760

The law requires that the death certificate be

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
- C

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA

1 TYes 2□ No

25. Was case referred to medical 1 Yes 2 No 27. Manper of Death

5 Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year)

and manner stated

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

2 ER/Outpatient 28b. Time of Injury

28c. Injury at Work? 1 □ Yes 2 □ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Matural

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4

APR 0 2 2008

29c. License number

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Payton Kurlen 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NorthWolfe Street Baltimore Maryland

Registrar

			For State Registrar	State of Maryla		artment of H		Mental Hy	giene Reg. No. 20	08	10605
494		2	Decedent's Name (First, Middle, Last)					2. Date of De	eath	Voor	3. Time of Death
	Physicia /Medic		Selena Stokes					Month 0 3	Day	Year 200 8	11:02 AM
-	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Death	1	4c. County		
	4			Medical Cente	А	Baltimore	If I had a Od I has	10.00		/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)	Cour	* '
Ļ,	Director		216 36 5348 Usual Residence of Decedent		,,,,,			FEB.1	9,1938	MD	
	/land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	10d. Inside City Limits
	Man a-f sh ified	ţċ	MD N/A		BALTI	MORE					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a ust b		127 S.CLINTON S				224		USA		
36	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2X No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Bla	ce - Americ ick, White, _{fy:} BLA	etc.
1215-0036	ifiled within 72 hou I Hygiene. other than "natura ent, the Medical E	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	1 (Give	dent's Usual Occupa kind of work done o DO NOT use retired	lurina most of woi	rking	16b. Kind of E	lusiness/In	dustry
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g	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar				
<u>Ja</u>	should be i and Mental I s marked of umatic eve	10 E	ALEXANDER REE	ED					JINN WI		
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Type		I	ng Address (Street a					
_	1 and Health em 27	1 7	20a. Method of Disposition		Place of Dispo	sition (Name of		Date	20c. Location		
<u>0</u>	ages ent of tt: If It		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei ING ME	matorý or other plac :M. PK.		,2008	BALTO	.co,	MD.
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21 in ature of Funeral Service Licenses	14		2. Name and Addres	100000000000000000000000000000000000000	-i			
ñ	an Jack		1) Ernadene V.	kung	1		PRESTON				1213
ı	- 10 - 10 - 10		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the de cause on each line.	ath. Do not ent						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Acute re	mal fai	Luxe					l week
1	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						
		<u>.</u>	Sequentially list conditions, b.	Due to (or as a conse	equence of):	15				-	1 week
7	nted Insit	Examiner	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events								
) O	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):						
8760	ate be	dical	d.							-	
). Box 6	ath certif ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome pf preg 1 Live birth 2 Fe 4 Pregnant at time of	taideath 3	□Ectopic pregnancy □ Other (specify)				ate of deliv	very Day Year
0	hat the		Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
ords,	w requires that the de been signed by the s should be detached i	ed by	End stage renal of	usease				1 []Yes 2□ No	3 □ Pro	bably 4 Unknown
Vital Records,	sician: The law r certificate has be irector, page 2 sh	Completed by						24a. Wa aut per 1□ Yes	opsy formed?	were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
VITE	certific ector,	Be	25. Was case referred to medical examiner?	ospital:		oth Oth	26. Place of De				
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O	th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
Division or	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, sti cify)	reet, factory, office		28f. Location City or T	(Street and Nun own, State)	nber or Rur	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicai Examin	clan: To the best of my k er: On the basis of exami and manner stated.	nowledge, deat nation and/or ir	th occurred at the time envestigation, in my o	me, date and plac opinion, death occ	e, and due to th urred at the time	e cause(s) and re e, date and place	nanner as	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sign		
			trh. M.D			RES	001		031	31/2	8008
	4		30. Name and address of person who cor			Print)	21224				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0.2 200	32 egistrar's Sig	nature &	rack	es 1 - 71 - 1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death C dtnoM Year **Physician** 755 M Dorothy, Mae. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimore Baltimore Medica Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1□M 2**X**F Days 218-28-3206 Director 07/03/1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at YYes 2 □ No Director Maryland n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 United States Funeral 11 W. Barney Street Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. Specify: White δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7 years College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other the any hijury or other traumatic event, the jones. n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thurman Watts Margaret Rubenstien 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Nash, Jr. (Son) 11 W. Barney St. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3-31-2008 Balitore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, 130 E. Fort Ave. Baltimore, MD J. Wayne Osterling 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 (YNo 24a. Was an autopsy perform 1∐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours are:
To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implicate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AM 2556996M246

A

State Registrar ohn

31. Date filed (Month, Day, Year)

02

2008

DHMH 17 Rev 1/2001

Baltimore

Panl

and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

301

Vital necolus, F.O. Box 66760,	F	Daimilore, Maryland 21213-00.
ysician: The law requires that the death certificate be executed	Phy /M Exa	permit. Pages 1 and 2 should be filed within 72 hours
is certificate has been signed by the attending physician and	rsic ledi amii	Important: If item 27 is marked other than "natural"

		State of Maryland / Depa State of Maryland / Cer	rtment of Health and tificate of Death		giene Reg. No. 2008	10607	
1. Decedent's Name (First, Middle, Last) Physician Danary Douglas Tillis				2. Date of Dea Month March	28, Day 2008 Year	3. Time of Death 9:50 a M	
/Medic Examin		4a. Facility Name (If not institution, give street and number) Wilson Health Care Center 4b. City, Town, or Location of Dec			4c. County of Death Montgomery		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 日 M 2 長 F 83 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		th y, Year) 9. Bird /1924	thplace (State or Foreign buntry) GA	
filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland wher then "natural", or flems 23a or 28a-f show what the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc 10b. County 10c. City, Town or Loc 10c. City, Tow				10d. Inside City Limits	
	recto	MD Montgomery Gaithers 10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	1X Yes 2 No ountry?	
eath with	Funeral Director	8440 Tea Rose Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20879 Vas Decedent of Hispanic Origin? (Specify Yes or No	USA - 14. Race - Ame		
ours after d ral", or Item Examiner	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ♣ No	Vas Decedent of Hispanic Origin? (Yes, specity Cuban, Mexican, Pue	rto Rićan, etc.)	Black, Whit Specify: Whi		
vithin 72 hc ne. han "natu	Completed	(Specify only highest grade completed) (Give	ent's Usual Occupation kind of work done during most of w OO NOT use retired) Omemaker	orking	16b. Kind of Business. Own Home	/Industry	
d be filed wental Hygie	Be	17. Father's Name (First, Middle, Last) Dan Douglas	18. Mother's Na	ame (First, Middle, a Thomps	Maiden Surname) On		
partition of some year of the first process. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. In moportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Name/Relationship (Type. Print) Lewis Tillis / Son 19b. Mailin 8440	g Address (Street and Number or F Tea Rose Drive,	Rural Route Numb Gaither	er, City or Town, State, sburg, MD 2	Zip Code) 20879	
		20a. Method of Disposition 1 ☑ Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	sition (Name of natory or other place) metery 4/	Date 3/2008	20c. Location - City or Fort N	Town, State Meade, FL	
permit. Departm Importa any injit			Name and Address of Facility Charles L. Steve 1501 East Fort A				
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/Medical Examiner		Due to (or as a consequence of):	ery Disease			years	
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	Be Co	25. Was case referred to medical examiner?					
Physic Prithis of Pral dire	유	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death			dence 6 Other (Spendern)	ecify)	
tal or Attending rs after death. al Director: Afte	Certification:	1 ★ Natural 5 □ Pending investigation 3 □ Suicide 6 □ Could not be determined to the princed of	M 1 Yes 2 No	28f Location /	Street and Number or F	Rural Route Number	
	Certif	4 ☐ Homicide determined building, etc. (Specify)		City or To	wn, State)		
he Hosp in 24 hou he Funei pletely fil	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
To the vithing the complete the	Ž	29b. Signature and title of certifier Puisco Oa Cal Olyphy Life Company	29c. License number 041794	,	March 28		
60		30. Name and address of person who completed cause of death (Item 23a) (Type, Priscilla Callodan- Aron MO 911 C	Print) Ussell Avenue	Gaithe	rs burg M		
Sta Registr		31. Date filed (Month, Day, Year) APR 0 2 2008 33. Registrar's Signature	and i	,	7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11: 35 AM **Physician** 80 Hemper 26 BurthoLonew 07 /Medical County of Death City, Town, or Location of Death Hame (If not institution, give street and number) Examiner BULTIMOR RI dle ver 8. Date of Birth Sept. 20,1935 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Social Security **Funeral** XXM 2□F Maryland 213-32-9495 72 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at White Marsh→ Baltimore County 1 Yes XX No Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21162 6016 Ebenezer Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes ¾ ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🎗 💢 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eastern Stainless Elementary/Secondary (0-12) College (1-4or 5+) Steel Co. Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Kroening Bartholomew Bernard Tremper ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6016 Ebenezer Rd. White Marsh, Md. 21162 19a. Informant's Name/Relationship (Type. Print) Phyllis R. Tremper (Wife) Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition X⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-31-2008 Baltimore, Md. Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) DISCase KIN SONS Physician /Medical Due to (or as a consequence of) **Examiner** Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy performe Yes 2 2□ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 2) No Hospital: 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A

oletely filled in by the fu death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

12

State

Registrar

29b. Signature and title of certifier

cause of death (Item 23a) (Type, Print)

29c. License number

D00619

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician 10:00 AM Jane Thomas Mar 30, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard **Ellicott City** 9308 Meadow Hill Rd If Under 24 Hrs. Hours Min. if Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 2/4F 65 256-64-0613 Director Nov 4, 1942 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No **Ellicott City** ns 23a or 28a-f sh must be notified Director MD Howard the 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 9308 Meadow Hill Rd. 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or iten edical Examiner 1 ☐Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other frammen. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Own Home** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1301 W. Northern Pkwy, Baltimore, MD 21209 Siiri McCafferty Personal Rep. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr 01, 2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) **Bayview Crematory** vice Lio see 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part Serier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovarian **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Por Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. detached 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ≥ 1 ☐ Yes 2**X** No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No page 2 s certificate 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: al or Attending Fafter death. After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatore and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	•	epartment of H Certificate of I		Reg. No.	10610
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) BERNADETTE Aa. Facility Name (If not institution, give street and Caroline Nursing & Reha		4b. City, Town, or Dent	2. Date of D Month March Location of Death	Day Year	
	Funeral Director		5. Social Security Number 214-01-2213 Cusual Residence of Decedent	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min. 8. Date of B (Month, D Aug. 2	irth (cay, Year) 9. Birth (co. 29, 1915 Ma:	nplace (State or Foreign untry) ryland
	Maryland a-f show	ctor	10a. State 10b. County Maryland Caroline	10c. City, Town Dento				10d. Inside City Limits 1 ☐ Yes 2 🗹 No
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 309 Sidney Lane		10f. Zip Code 216		10g. Citizen of What Co	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny injury or other treumetic event, the Medical Examinar must be notified at 2008.	þ	Armed 1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. Forces? s 2 M No Give r Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) Specify:		
Maryland 21215-0036	d within 72 hagene.	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 10 0	d) 16a. (e (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired Homemake	furing most of working)	16b. Kind of Business/	
pur	be filed htal Hyg event,	Be	17. Father's Name (First, Middle, Last) Peter Joseph Cunningl	nam		18. Mother's Name (First, Middle Barbara	e, Maiden Sumame) Mary Zant	
Maryk	12 should h and Mer 7 is marke treumetic	2	19a. Informant's Name/Relationship (Type, Print)	19b.		and Number or Rural Route Num	ber, City or Town, State, 2	
Baltimore, I	Pages 1 and nent of Healt nt: if item 2 iry or other		20a. Method of Disposition 1	20b. Place of I	Disposition (Name of c, crematory or other place	Date	20c. Location - City or Glen Burnie	Town, State
Balti	permit. Departm Importa eny inju		21. Signature of Funda Service Licensee	unh	22. Name and Address McCully-Pol 3204 Mounta	s of Facility Lyniak Funeral H ain Road, Pasade	Home P.A.	d 21122
	Physician /Medical Examiner		23a. Patr. Enter the disease, or complications the rock, or heart failure. List only one cause of introdiate Cause (Final disease or condition resulting in death) a	at caused the death. Do not no each line.	ot enter the mode of dyin			Approximate Interval Between Inset and Death
760,	le be executed ysicien and e burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of				
P.O. Box 68		Physician/Medi	in the past 12 months?	outcome of pregnancy e birth 2 ☐ Fetal death egnant at time of death known	3□Ectopic pregnancy 5□ Other (specify)		23d. Date of del Month	ivery Day Year
	quires that the dei n signed by the a uld be detached f	d by Pt	Part II Other significant conditions contributing to	o death but not resulting in	the underlying cause give		l tobacco use contribute to	/
Reco	The law rec te has bee age 2 shou	Completed by	Coronary Al	tery	lise	24a. We aut per 1 □ Yes	opsy prior to death?	topsy findings available completion of cause of
f Vital	ysician: is certifica director, p	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Out	patient 3☐ DOA Oth	26. Place of Death (Check only	one)	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	te of Injury onth, Day Year) 28b. Ti In ace of Injury - At home, fare illding, etc. (Specify)	jury Worl	Yes 2 □ No 28f. Location	e how injury occurred (Street and Number or Ruown, State)	ural Route Number,
	he Hospit n 24 hour he Funera	Medical C	(Check only 2 Medical Examiner: On the	the best of my knowledge, e basis of examination and anner stated.	death occurred at the tin Vor investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	e cause(s) and manner as a, date and place, and due	stated. to the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifier	Side!	29c. Licens	3 1376	29d. Date signed (Mont.	h, Day, Year)
	Le		30. Name and address of person who completed c			Center , Dento	n. Marvland	21629

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 0 2 2008 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** March 5: U5 P M WAShin QЯ Ganne 2008 /Medical 4c. County of Deat Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ta 1 JE CU yes Balti Ci OR E 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 52 Yrs. 8. Date of Birth (Month, Day, **Funeral** Days 215-74-1 M 2 M Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or forther traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 No Baltimore, Maryland 21215-0036 2 No Blac Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unemploye 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) inner ٥ Rural Route Number, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CRME 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the state, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest Immediate Cause (Final **Physician** NON CARdiomyopath isour mi resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) Yes 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 2 ☐ No 3 ☐ Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes 2 □ R/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after deam.
e Funeral Director; After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBINSON 2000 WEST 1timor 5 MA 31. Date filed (Month, Day, 32. Registrar's Signature Year! State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Jotham Earl Watson 1:02 PM 2008 areh 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 218 14 7168 87 Boone, North Carolina February 7 1921 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 □ No Maryland Harford Directo Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Timber Trail Unit C 21014 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2√1X No Specify: Specify: 3 Widowed 4 Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Construction Commercial Buildings other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filk thent of Health and Mental Hitant: If item 27 is marked oth Be Jotham Ezra Watson Margaret Blackburn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris K Watson 200 Timber Trail Unit C Bel Air, Maryland 21014 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. March 31 2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory firest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 20 tec /Medical Due to (or as a or sequence of): Examiner rentro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Discitu (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical as the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 □ No 3 Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 242 No certificate l 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Plarch 28, 2008 DO053568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

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Watson

32. Registrar's Signature

Wilson, Mary E Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MARY ELIZABETH WILSON

4a. Facility Name (If not institution, give street and number) AM 11:00 MARCH 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year | If Under 1 1000 S. EAST AVE.
Social Security Number 6. Sex 1 Year If Under Hours Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛣 F 218-44-4630 Usual Residence of Decedent Director JUNE 29 1941 MARYLAND death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 □ No Directo MARYLAND

10e. Street and Number BALTIMORE 10g. Citizen of What Country? a or ms 23a must b 1000 S. EAST. AVE S. A.
Race - American Indian, 2/1 Funeral ural", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite, any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the M Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOPHIE OGLE ၉ FLMER CHARLES JANUARY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MARIE MCKEE/ceusin 7/1 S. CRUNDY ST., BALTIM CRE, M.D., 212.24

20a. Method of Disposition

1 TRurial 2 FiCremation 3 TRemoval from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 1 ☐ Burial 2 DaCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAY VIEW CREMATORY APRIL 1, 2008 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
LILLY + ZEILER, INC. FUNERAL HOME
1901 ERCTERN AVE. BALTIMORE, MD. 21231 Patherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VARIAN CANCER **Physician** Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 2▼No certificate To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1. Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DWIGHT IM, MD 227 51. PM PLACE. BALTIMURE PAUL DWIGHT 31. Date filed (Month, Day, Year) APR 0 2 2008 32. Registrar's Signature State Registrar

			For State Registrar	State	of Marylar		rtment of H		Mental Hygi	ene 200	8 10614		
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of Death Month		3. Time of Death		
	Physici /Medi		Katharine C.	Worthingt	on				March 17	, ^{Day} 2008 Ye	10:25 PM		
1	Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death	1	4c. County of D	eath		
			523 Broadwate	r Way				n Island		Anne A	rundel		
	Funeral Director		5. Social Security Number 217-46-2917	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. 60	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 16,	1947 Wa	Birthplace (State or Foreign Country) ashington DC		
	and *		Usual Residence of Decedent 10a. State 10b. Count	v	10c, Cit	ty, Town or Lo	cation				10d. Inside City Limits		
	Aaryli • ho	ō									1 ☐ Yes 2 ☑ No		
	28a-	ect	MD Anne 10e. Street and Number	Arundel		Gibson	Island 10f. Zip Code		10	g. Citizen of What			
	with a or	ā	523 Broadwate	r Way			,	21056	.5	USA	. Journal of the second of the		
	ne 23	era	11. Marital Status	12. Was De	cedent Ever in U	l.S. 13. V			pecify Yes or No-		merican Indian,		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23s or 28s-f show appringuty or other treumatic event, the Medical Exeminar must be notified at once.	by Funeral Director	1 Never Married 2 Ma. 3 Widowed 4 Divorce	rried Armed F	orces? 2 ☑ No live		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2X No	Specify:	o Rican, etc.)		white, etc.		
2-0	72 ho	Completed	15. Decede	nt's Education est grade completed	0	16a. Deced	lent's Usual Occupa	ition	ting 1	6b. Kind of Busine	ess/Industry		
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21	ygien ygien t, th	Co	12	4		a	nalyst				L systems		
Maryland	d oth	Be	17. Father's Name (First, Middle						ne (First, Middle, M	aiden Sumame)			
<u>ya</u>	Men Men Brke	၉	Joseph Muse W		n .			Kathari					
Jar	2 sh and le m		19a. Informant's Name/Relation						ıral Route Number,				
6	and lealth m 27 her t		Joseph Worthin	gton/brot				Road Al	exandria,				
Baltimore,	Pages 1 ment of H ant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Specify)	State	cemetery, cren	sition (Name of natory or other place	9)	Date 2	0c. Location - City	or Town, State		
Balt	Departi Departi Import eny inj once.		21. Signature of Funeral Service Ronald	S. Wade,	Directo		Name and Addres ate Anato ltimore.		1 655 W. 1	Baltimor	e Street		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	complications that	caused the deat					st,	Approximate Interval Between		
	Physician		Immediate Sause (Final disease or condition a. L. WW Collapse										
/Medical resulting in death) Due to (or as a consequence of):							11	2/12			11/		
	Examiner		Sequentially list conditions	b	SN	nalle	SILL	long	Came	w	17		
	p	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	quence of):			\				
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C					7				
, 0,	sian a	Ē	resulting in death) Last	Due to	(or as a conseq	(uence of):							
8760,	icate be executed physician and s the burial-transit	dical		d									
× 6	leath certific attending p	/Me	IF FEMALE:	22a Hugo a	teems of every								
Вох	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 ☐ Feta anant at time of d	ıl death 3□	Ectopic pregnancy			23d. Date of Month	delivery Day Year		
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unk		ieatn 5∟	Other (specify)						
٥.	that the by detac	P.	Part II. Other significant condit	ions contributing to	death but not res	sulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	icco use contribut	e to the cause of death?		
Records,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by							1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown		
Ö	hasb 182sh	ple							24a. Was an autopsy	prior	autopsy findings available to completion of cause of h?		
		ő							perform	No 1 □	h? Yes 2□ No		
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one)			
of \	Physi this c	၉	1 ☐ Yes 2 No			ER/Outpatien		4 🗆 Nursing A			Specify)		
	DS 00 00	e E	27. Manner of Death 1. ■ Natural 5 □ Pendi	ng (Mo.	of Injury nth, Day Year)	28b. Time of Injury	28c, Injury Work		28d. Describe hov	v injury occurred			
sio	Attending at death. ector: After by the funer	cat	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	igation not be				′es 2 □ No					
Division	lor At after o Direct	Certification;	4 Homicide deterr	ning 280, Plac	e of Injury - At hi ding, etc. (Specif	ome, farm, stre fy)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,		
_	spital		29a. Certifier 12 Certifyi	ng Physician: To th	e best of my kno	owledge, death	occurred at the tim	e, date and place	, and due to the cau	ise(s) and manne	r as stated.		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune.	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or inv	estigation, in my op	inion, death occu	irred at the time, dat	e and place, and	due to the cause(s)		
	Viit To Con	2	29b. Signature and title of certific	ALIAMA	H	COCIF	E 29c License	number / h	29	d. Date signed (M	(onth, Day, Year)		
,			X M MAI W	mine	/ PK	CUTE	10E 17	4100		121	UU		
			30 Name and address of person	USNE	R, MD	n 23a) (Type,	Pouth C	reene	Street	Balt	i more M		
	Sta Registr		31. Date filed (Month, Day, Year APR 0 2 2	008	Registrar's Sign	ature	وم		/	,			

1. Decedent's Name (First, Middle, Last) Mar 23, 2008 Year **Physician** 11:05 A_M Katherine Rebecca Yates /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Catonsville 120 Smithwood Ave If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec 29, 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Min MD 1 □ M 91 215-07-5311 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Catonsville Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21228 120 Smithwood Ave death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after d al Hygiene. other than "natural" or item Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2LXNo White 1 Tyes Specify: 2 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking **Bookkeeper** permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Brass Frank Ridgley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3812 Byxbee Rd. Randallstown, MD 21133 J. Edward Yates Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Ellicott City, Maryland Mar 26, 2008 Good Shepherd Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Part1. Emir the disheshock, or heart fail re. e, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. 23a. Part1. terval Between nset a**n**d Death Immediate Cause (Final disease or condition resulting in death) roke **Physician** deu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown cate has been signed by page 2 should be detach contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes perform certificate 2□ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13 (Item 23a) (Type, Print) Kare -och 31. Date filed (Month, Day, Year) APR 0.2 2008 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

State Registrar

			1 - For State Registrar		of Mary		partmer ertificat					Reg. No.	008	10616
Г	Physici	an	Decedent's Name (First, Midd								2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	cal	CARL 4a. Facility Name (If not institution		HCRAF'	ľ	4h Chi	Town or	I continu	of Dooth	March	14	2008 unty of Death	1:45 P
	Examir	ier	Woodside						Location o		-			0.50
-	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthd	y) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth	1	ntgome 9. Birthp	place (State or Foreign htry)
b	Director		245-38-2557	XX ^M 2□	F 80	Yrs	Months	Days	Hours	Min.	(Month, Day		N.	
	pu »		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or								0d. Inside City Limits
	shor	5		N/A	10	Washi								1x21x es 2 □ No
	28a-1	Director	10e. Street and Number					Code		-		10a Citizen	of What Cour	
	an or	ā	1859 Ingles	side Te	rr .	N W		2001	10				.S.A.	
	ier death w items 23a	Funeral	11. Marital Status	12. Was [Decedent Ever					gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	
9	after or ite		1 ☐ Never Married 2 ★ Mar		d Forces? es 2 No		If Yes, spe				Rican, etc.)		Black, White, ecify: Black	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examination mollited at	d by	3 Widowed 4 Divorced	Year	or Dates:		TE Tes	ALANO	эрөспу.			30	ecity: DIC	acx
15-	"nati	Completed	15. Deceder (Specify only highe	nt's Education est grade complete	ed)	16a. De	cedent's Usu ive kind of wo b. DO NOT u	al Occupa	ation during most	t of work	ing	16b. Kind	of Business/Inc	dustry
12	within ene. than "	duc	Elementary/Secondary (0-12) 3rd	Colleg	ge (1-4or 5+)		ruck					Pr	ivate	
D	e filed within al Hygiene. I other than ' vent, the Me	0	17. Father's Name (First, Middle,	Last)						er's Name	First, Middle,			
Maryland		To B	Levi Asl	ncraft					Γ	Dais	ey Sta	ton		
lar	2 should be and Ment is marked		19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	ailing Address	s (Street a	and Numbe	er or Rura	al Route Numbe	r, City or To	own, State, Zip	Code)
	of Health of Health litem 27 i		Delores M. A	Ashcraf					side		r. N.W			20010
Baltimore,	Pages 1 nent of H int: if ite iry or ott		20a. Method of Disposition 1 Cremation	3 Removal fr		Ob. Place of Dis cemetery, of	position (Na rematory or o	me of other plac	e)		Date	20c. Locat	ion - City or To	own, State
ţ	t. Pa ntmen rtant: njury		'4 □Donation 5 □Other (5		, 1	Harmon				3/2	2/08	Land	over,	Md.
- Ba	permit. Pages Department of Important: If I any injury or once.		21. Signature of funeral Service	D. H	acket	An.	Hack 814-	ett'	S Fu	iner Str	al Cha	pel,	Inc.	
			23a. Parth. Enter the disease, o shock, or heart failure. List	r complications th t only one cause o	at caused the on each line.	death. Do not	enter the mod	de of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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ı	/Medical Examiner		resulting in death)	Due		nsequence of):	-							
		-	Sequentially list conditions, if any, leading to immediate	b. — Due	to (or as a co	nsequence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	HTN	2							- 5	
oʻ	exec an an		resulting in death) Last	C. Due	to (or as a co	nsequence of):								
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Вох	death certific e attending pl id for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	1 □ Liv	outcome of prive birth 2	Fetal death	3 □Ectopic p					23d	. Date of delive Month	ory Day Year
o.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time nknown	of death	5 ☐ Other (sp	oecify)						,
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rds,	quires n sign ald be	d by	Dement	ia f	OND						1 🗆 Y	es 2 🗆 N	lo 3 🗆 Prob	ably 4 💆 Unknown
000	aw requir as been si 2 should	Completed									24a. Was a		4b. Were auto	psy findings available
æ	The la	шо									autop perfor		death?	mpletion of cause of
ţa		Be C	25. Was case referred to medica examiner?	t					26. Place	of Death	(Check only or		12 100	20110
<u>></u>	di S	2	1 Yes 2 No	Hospital:	□Inpatient	2 ER/Outpat	ient 3 DC	Othe Othe	er: XX Vu	rsing Ho	me 5 Resid	ence 6	Other (Specify	y)
ū	ding P h. After t funera	on:	27. Manner of Death 1. □ Natural 5 □ Pendir		ate of Injury Io <i>nth, D</i> ay Ye	ar) 28b. Time Injur		28c. Injury Work			28d. Describe h	ow injury or	ccurred	
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Division of Vital Record	after death Director:	Certification;	4 Homicide determ		uilding, etc. (S	At home, farm, oecify)	street, ractory	у, опісе			City or Tow		uniber or Hura	d Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To Examiner: On the and m	the best of my e basis of exa nanner stated.	/ knowledge, de mination and/or	ath occurred investigation	at the tim	e, date and pinion, deat	d place, a	and due to the ded at the time, d	ause(s) and date and pla	d manner as stace, and due to	tated. o the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifie				290	c. License		-	2		igned (Month,	
	L		1 am	nord				D65	301			Mar	17,	2008
	T		30. Name and address of person				,							
			FARZANA)1 – 2ı	nd S	t. S	ilv	er Spr	ing,	Md. 2	20910
	Sta Registra		31. Date filed (Month, Day, Year) MAR 1 9	2008	Registrar's S	Signature S	arte							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) Day 2008 Physician Carolyn 15, \mathbf{L} Anderson 9:20 p M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13810 Congress Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 □ M 2 🔀 F 579-16-0345 Director Nov. 10, 1918 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 2 is marked other than "---- any Injury or other team." 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes X ☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13810 Congress Drive 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2€ No Specify:White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Hoyt Lamb Marion Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Birthday Court, Brookeville, MD 20833 Carl E. Baucom/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 2008 Fort Lincoln Cemetery 4 Donation 5 Dother (Specify) Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd., W. Silver Spring, MD 20901 23a. Part1. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 8 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? al or Attending Physician: Telfer death.
I ulrector After this certificat d in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) d title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature a 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) ///6/ New Attampshire Nonve 31. Date filed (Month, Day, Year) Registrar's Signature State 1 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 1:15 AM REE ADKINS 2008 4c. County of Death Mar. 15 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Laurel Health & Rehab Laurel Prince George's If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Funeral Days Months 1 □ M 2 💢 F Director 255-26-0010 86 April 6. Georgia Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a State 10h County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Beltsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with t 11905 Gordon Ave. 20705 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife. Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 Is marked oth any Injury or other traumatic event, once. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) Sharon C. Day -stepdaughter 11905 Gordon Avenue Beltsville, Maryland 20705 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) (unk) Metropolitan Crematory Alexandria, Va. 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Rd. Beltsville, Md 21. Signature of Funeral Service Lic of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease of Inijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🂢 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? res 2X No 2 💢 No 1 🗌 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA မ After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the hours after organization 24 hours after organization 24 hours after organization 24 hours after To the Funeral Director: After a particular filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Du053709 March 17, 2008 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raj Kumar Chawla, M.D. 14200 Laurel Park Drive Laurel, Maryland 20707

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 9 2008





		State of Maryland / Dep			2000 10614
		1 - Seate Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. 2. Date of Death	3. Time of Death
. Physicia /Medic		Nina Ehrenfeld Beasley			7 2008 3:05 A ^M
Examin	- 18	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
Funeral		2700 Summerview Way, Apt. 203 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)) If Under 1 Year if Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
Director		179–20–9263 ¹□м²⋈F 81 yrs.	Months Days Hours Min.	June 13,	1926 Pennsylvania
land Sw t		Usual Residence of Decedent 10a. State 10b. County 10c. Cify, Town or L			10d. Inside City Limits
Mary a-f sho ified a	ctor	Maryland Anne Arundel	Annapolis		1 □ Yes 2/□ No
h with the 3a or 28 st be not	Funeral Director	10e. Street and Number 2700 Summerview Way, Apt. 203	10f. Zip Code 21401	10g.	Citizen of What Country? U.S.A.
ING 21215-0036 be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ↑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21 5-0036 hin 72 hours af h. "natural", or Medical Exam	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Industry
d Z1Z15- filed within 72 Hygiene. other than "na" ent, the Medic	Com	2	Homemaker	e (First, Middle, Mai	Own Home
	To Be	17. Father's Name (First, Middle, Last) Walter Spahr Ehrenfeld		a Alvord	den Surname)
		1 () ,	ling Address <i>(Street and Number or Run</i> 2 Catlyn Place Ann		
		11 Burial 2X X remation 3 Bemoval from State 1	ematory or other place)		c. Location - City or Town, State
Baltimo permit. Page Department o Important: If any Injury or			re Crematory 3/20, 22. Name and Address of Facility Job		altimore, Maryland
on Spen		Todd & helle	147 Duke of Glouces	ster St.,	Annapolis, MD 21401
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	cular accider	. (,	
Examiner					
ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events			
58 760, icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760 ate be e hysician the buris	dical	d			
Box 6 leath certific attending p	/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
Hecords, P.O. Box 6 The law requires that the death certific te has been signed by the attending to tage 2 should be detached for use as	Physician/Me		B Ectopic pregnancy Other (specify)		Month Day Year
cords, P.O. w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobac	cco use contribute to the cause of death?
Ord: require een sig	ted t	C.O.P.D., CHRONIC CON	GESTIVIZ HEART	1 ☐ Yes	2 No 3 Probably 4 (Month)
	Completed	FAILUNE		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
r VIta ysician: is certific director,	Be	25. Was case referred to medical examiner? Hospital:	Other	th (Check only one)	
g Physer this leral di	n: To	1 Yes 2 No	of 28c. Injury at	ome 5 ≯ Residend 28d. Describe how	ce 6 Other (Specify) injury occurred
tending Physical Control of the funeral direction of the funeral direct	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION OF plan or Attending Physical or Attending Physical Director: After this filled in by the funeral di	Certification:	4 Homicide determined determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, S	et and Number or Rural Route Number, State)
DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
To th Within To th comp	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
		1 Whatoho	124748		3-17-08
Most		30. Name doe address of person who completed cause of death (Item 23a) (Type DASSS, wm A 277 Peninsula Farm		land 2101	12
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#23a-a per PhyState of Maryland / Department of Health and Mental Hygiene State Registrar 3/21/08 cmh AMCO HEALTH DEPT Certificate of Death Red. No. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 13 2008 10:40P ^M Hazel E. Brown March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Severna Park Center Severna Park
If Under 1 Year | If Under 24 Hrs. Arunde1 <u>Anne</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2√2 F 83 Yrs. 10 1924 Maryland 214-18-3178 Apr Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location la or 28a-f show t be notified at 1√2Yes 2□No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 701 Glenwood St. 21401 23a Apt 305 USA 7 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w th and Mental Hygier 7 is marked other th 12th n Custodian House of Delegates 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Brown Mary Brice ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Sandra Solomon(Sister) 123 Eastern Ave Annapolis, Md. 21403

pe of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of compare) compared to the place of the compared to the place of the place o 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 3-19-08 Annapolis, Md. Wmame Reactes of Scilicons Mortuary, P.A. 21. Signature of Funeral Service Licensee Beese MOOY83 821 West St. Annapolis, Md. avry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heart Failure Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 ☐ Unknown signed by t I be detach 23e. Did tobacco use contribute to e cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 robably 4 ☐Unknown Be Completed 34b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 200 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

30 Mame and address of person who completed cause of death (Item 23a) (Type, Print)

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			State of Maryland / D	Department	of Health and M		3	
	_		noglona.	Certificate	of Death	Reg	J. No. 2 0 0	8 10621
124	Physici	an	1. Decedent's Name (First, Middle, Last)			Month March	Day Year	
	/Medi		Richard Reedy Betts 4a. Facility Name (If not institution, give street and number)	4b. City. To	own, or Location of Death	15 2008 4c. County of Dea		
	Examir	ier	Union Hospital	1	lkton		Ceci	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday) If Under 1		8. Date of Birth (Month, Day,)	9. Bi	rthplace (State or Foreign country)
	Director		213-52-5284	Yrs.	Days Floors Will.	Aug. 14,	1948 N	faryland
	and w t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
	Maryl -f sho fied a	tor	Maryland Cecil Elki	ton				1 X Yes 2 □ No
	nr 28a nr 28a	irec	Maryland Cecil Elki 10e. Street and Number	10f. Zip C	Code	100	g. Citizen of What C	country?
	23a cust be	al D	228 Courtney Drive		21921		USA	
	tems termi	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decede If Yes, specif	ent of Hispanic Origin? (S fy Cuban, Mexican, Puert	pecify Yes or No- po Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	y F	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give Year or Dates:	1 □ Yes 2	▼ No Specify:		Specify:	m.i.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by	15. Decedent's Education 16a.	Decedent's Usual	Occupation	116	b. Kind of Busines	White s/Industry
215	e. an "n Medi	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work life. DO NOT use	done during most of wor retired)	king		
S	ed withi ygiene. ier thar t, the M	S	10 Ec	quipment	-		State Hi	ghway
gue	be fill htal H hd ott even	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	<i>'</i>	
Maryland	12 should be filed w h and Mental Hygiel is marked other ti raumatic event, th	ပ	Alvin Betts 19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Elizab Street and Number or Ru	<u>eth Smith</u>		Zin Code)
Ma	od 2 s Ith an 27 is r				ney Drive,			2.10 0000)
Ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of	Disposition (Name	e of		Oc. Location - City of	r Town, State
Baltimore,	Page nent c int: If		1 Burial 2 XI Cremation 3 Li Removal from State		neral Home,		ising Sun	, Maryland
alti	porta porta y Inju		21. Signature of Funeral Service Licensee	22 Name and	Address of Facility oard and Jor			· · · · · · · · · · · · · · · · · · ·
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R			Part1. Enter the discrete, or complications but caused the death. Do r shock, or heart fail the complex caused the death.	not enter the mode	of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL		CTION			HOURS
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	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	.000				YEARS
,092	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Ĕ	resulting in death) Last Due to (or as a consequence of	of);				
6876	ate b	dical	d					
9 X	ding p	Physician/Medi	IF FEMALE: 23c. If yes, outcome pf pregnancy	- Constitution			Old Date of d	ali can c
Вох	atten for u	cian	in the past 12 months?	3 ☐Ectopic preg			23d. Date of d Month	Day Year
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	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cau	use given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	equire en sig ould b	ed t				1 ✓ Yes	2 No 3 I	Probably 4 Unknown
မင္ပ	law ra as be	Completed				24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u>~</u>	The cate h	Son				1 Yes 2	ed? death? □ No 1 □ 76	es 2 No
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examine 17		Other:	th (Check only one		WOOD STATE
ō	Phys	<u>۲</u>	1 Inpatient 2 K EH/Ou	· 	4 U Nursing H	ome 5 Resider 28d. Describe hov		necify)
on	nding th. : Afte e fune	tion		njury M	lc. Injury at Work? 1 ∐ Yes 2 ∐ No		,,	
Division or Vital Records,	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory,	office	28f. Location (Stree City or Town,	eet and Number or i	Rural Route Number,
	ital or rs afte ral Dil	Cerl						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 29a. Certifier 1 ✓ Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	, death occurred a id/or investigation, i	it the time, date and place in my opinion, death occu	e, and due to the car urred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	29c.	License number	29	d. Date signed (Mo	nth, Day, Year)
	,		≥ 4 MO	0	0047711		MARCH	19,2008
	6		30. Name and address of person who completed cause of death (Item 23a) (51 H = C1			2100
			DAY NO GAY-EL 304-306 NorzL St 31. Date filed (Month, Day, Year) //32. Registrar's Signature		in #3 El	HTUW MY	MYLAND	21921
70	Sta Regist		31. Date filed (Month, Day, Year) WAR 2 0 2008	porte				

		•	For State of Maryland State State Registrar		artment of H tificate of L			eg. No.2	008	10622
ø	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month March	Tay 16	2008	3. Time of Death 4:20 P M
	/Medic	al	Walter Thomas Bush 4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	<u></u>		ounty of Death	4:20 P M
	Examin	er .	NMS Healthcare		Hagers			Washington		
	Funeral Director		5. Social Security Number 408−22−0372 6. Sex 12 M 2□ F 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/08/1	Year) 918	9. Birthpl Count	ace (State or Foreign try)
	rland ow	-	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	e Man sa-f sh tified	ctor	VA Fairfax	Vienn	a					1 Mg Yes 2 □ No
	ath with th 23a or 28 ust be no	ral Director	10e. Street and Number 912 DeSale Street, S.W.		10f. Zip Code	22180			of What Coun US	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 33 Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 23 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No			Sį	Journy.	ite
15-0	n 72 h ''natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life, L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work d)	king	16b. Kind	of Business/Ind	lustry
212	d withii glene. r than the M	omo	Elementary/Secondary (0-12) College (1-4or 5+)		Printer]	Newspap	er
Baltimore, Maryland 21215-0036	12 should be filed wand Mental Hygie Is marked other traumatic event, th	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Edward McKissick Bush				ne (First, Middle, I Belle Sai		ırname)	
, Mary	and 2 shore ealth and A n 27 is ma		19a. Informant's Name/Relationship (Type. Print) Carol Bush / Daughter	150	ng Address <i>(Street</i>) S. Marsh	nall Stre		-		
ore	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 A Buriai 2 Licremation 3 Kinemoval from State 1		sition (Name of matory or other place	1			tion - City or To	
E E	urtmen urtmen urtant: njury		4 □ Donation 5 □ Other (Specify) Nat 21. signature of Funeral Service Licensee		Mem. Par				Church Fu	n, VA meral Home
Ba	permit. Departr Imports any inji		Lane N. Thui	11	102 W. Br	oad St.,	Falls Cl	hurch		
7			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		le Hea	at F	ailure			- Choot and Dough
	Examiner			erice or):	Fibr	1110110	~			
4	o #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
_	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		ension	<u>~</u>				
68760,	ficate be executed g physician and ss the burial-transit		d	,						
_	- D m	Medical	IF FEMALE:							
O. Box	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	,		230	d. Date of delive Month	ery Day Year		
S,	ss that gned b	by Pt	Part II. Other significant conditions contributing to death but not result	iting in the u	nderlying cause giv	en in Part I.	23e. Did to			ne cause of death?
ord	w require been sig should t		Dementia				1 □ Y	es 2	No 3☐ Prob	ably 4 Denknown
Vital Records,		Completed					24a, Was a autops perfor 1 Yes	sy med?	24b. Were auto prior to cor death? 1 ☐ Yes	psy findings available npletion of cause of
VIta	sician: certific rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		ot all DOA Oth	or:	th (Check only or			
ō	ding Phys h. After this funeral di	. To	27. Manner of Death 28a. Date of Injury	28b. Time o	IL SO DOA	4 Lanursing H	ome 5 Resid			y)
ioi	ending ath. or: Afte he fun	ation	1 ☐ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		Yes 2 □ No				
Division or	al or Attendate after death	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At hor building, etc. (Specify,	ne, farm, str)	eet, factory, office		28f. Location (S City or Tow	treet and i n, State)	Number or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.							
1	To the within to the comp	Me	29b. Signature and title of certifier Tarial		29c. Licens	e number			signed (Month,	
•	(5		30. Name and address of person who completed cause of death (Item				on I	cF	a 21°	740
Ų.	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 9 2008	ure	Will I	agerst	,			
				-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2008 CATHARINE Ε. BUNNELL-MINCEY MARCH 16. 11:42 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 🖫 F Davs 52 Director DEC. 29, 1955 MARYLAND 217-70-3354 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
 1 is marked other than "natural"; or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1√2 Yes 2 □ No Director MD. PRINCE GEORGES HYATTSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4011 INGRAHAM ST. 20781 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 Widowed 4 Divorced WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natu other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) COLUMBIA LIGHTHOUSE Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF ALTERNATE FOR THE BLIND FORMAT CENTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HUGH FRANCIS BUNNELL DOROTHY MAE GILBERT ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum WILLIE Ε. MINCEY/HUSBAND 4011 INGRAHAM ST., HYATTSVILLE, MD. 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. PATRICK'S CEM. 3-24-2008 | MIDDLETOWN TOWNSHIP, PA. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licenses M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed the burial-tran Due to (or as a consequence of) ohysician as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign be c þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 has 1 Yes Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To this After thi 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation Injury 1 Natural hours af er death.

uneral Director: Af
ely filled it by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 17, 2008 D0055918 MD 30. Name and add as of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVE, TAKOMA PARK, MD 5. KOSS SWITKES M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 19 2008 Registrar

State Registrar

31. Date filed (Month, Day, Year) MAR 1 9 2008

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March 16, 2008

IBND TIPM#20b, perFH_C878,472/08,WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CHARLES BLACKISTON MARCH 2008 26 10:05 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chester River Hospital Chestertown Kent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1₫M 2□F 215-26-5128 Yrs. Director 84 1923 Maryland 8 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a, State 28e-f show the Medical Examiner must be notified at 1 Yes 2X No Directo MD Queen Anne's Chestertown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 108 Merganser Dr. 21620 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Hems 11. Maritaf Status filed within 72 hours after 1⊠Yes 2□No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. þ 3 Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other treumatic event, the Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daniel Washington Blackiston Beatrice Harbinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George McMullen 272 St. David Dr. Mt. Laurel, NJ. 08054 (son) 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Crumpton Cemetery March 31, 2008 Crumpton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 Approximate Interval Between 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition **Physician** DUL Minans resulting in death) /Medical (or as a consequence of) Examiner Lalon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Physician/Medical Examiner ud or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit S/a that initiated events resulting in death) Last and Due to (or as a consequent P.O. Box 68760. the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown deneuro 1 Yes 2 No peen rabeles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No certificate hu tusen 2 No 25. Was case referred to medical examiner? 1 ☐ Yes director. 26. Place of Death (Check only one) Medical Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation 1 Tes 2 No М death. nerel Director: A filled in by the fu 2 T Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after within 24 hours a To the Funerel I 1(2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arrabel, John C. M.D 223 High St. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2008 Year **Physician** 25 7:05 A.M Ann Blank March Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 798 Motter Ave. Apt. Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X** ☐ F Months Davs Hours Min 214-42-2254 Director Maryland 63 May 2, 1944 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10h County 7 Is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland | Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 798 Motter Ave. Funeral Apt. 302 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) housekeeping 10 hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Hanshew Maudie A. Ramsburg ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 Is m any injury or other traum once. Brenda Cooper / daughter 1741 Carriage Way, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Olivet Cemetery | 03/28/2008 Frederick, Maryland 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses hue MO1222 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to lovas a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the aftending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) Manne⊯of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1, Natural 5 Pending 1 TYes 2 TNo investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Legitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 0 44164 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)



HEGAZIND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lorena Coburn /Medical March 14 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 👽 F Yrs Director 215-58-2305 8/28/1951 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 420 Regester Ave. 21212 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Johns Hopkins Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event; the Mones. College (1-4or 5+) registered nurse <u>Hospital</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Coburn Phyllis Clow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas Coburn, brother 4335 Mt. Zion Rd., Upperco, Md. 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Carroll Cremation Inc. 3/16/08 Hampstead, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 934 S. Main St., Hampstead, Md. 21074 Approximate Interval Between Onset and Death 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, from leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a nonsequence of: sician and burial-trans Due to (or as a consequence of): physician sthe burial Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No Vital 1 Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1, Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

6701 32. Registrar's Signature

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

MArch 14, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Christopher Helen Naomi 10:25a^M 2008 March 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 ☐ F Director 215-01-7043 04/06/1917 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits an "natural", or items 23a or 28a-f show Medic-I Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Hampstead MD. Carroll 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21074 USA 1010 Highfield Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) the own home homemaker s 1 and 2 should be filed v f Health and Mental Hygie item 27 Is marked other t other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Mae Canapp McClellan Martin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; if item 27 any Injury or other tr. 1010 Highfield Drive, Hampstead, Md. 21074 Nancy Conner, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pine Grove Cemetery 3/18/08 Parkton, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home Lemmer M00741 Handa 934 S. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (r as a ornsequence /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes 2 🗓 N 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ ₩ 1 hpatient 2 ER/Outpatient 3□ DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending thours after death.

-uneral Director; Afely filled in by the ful 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 54218 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcolm dure, Wertminster 340 2115r Kanenia 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MATTIE COLE 17, MARCH 2008 1850 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JULY 16, 1941

9. Birthplace (State or Foreign Country)

WASHINGTON, DC 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 □ M 2 👿 F 66 Director 215-86-0122 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 XYes 2 No Director BELTSVILLE MARYLAND PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ral", or items 23a or Examiner must be r 20705 UNITED STATES 10904 DRESDEN DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. <u>^</u> 3 Widowed 4 Divorced BLACK "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NOT APPLICABLE NOT APPLICABLE 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE OSCAR COLE, SR. FLORENCE EDNA BAKER COLE r 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if item 27 is any Injury or other trau 3375 MALCOLM ROAD, BRANDYWINE, MARYLAND 20613 JAMES ROBERT COLE, JR./NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. MARY'S CHURCH CEMETERY MARCH 25,2008 NEWPORT, MARYLAND 4 Donation 5 Dother (Specify) Stature of Fun-14 Serva Licensed THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cone Physician Lung disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: #
filled in by the fi 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andella, mo. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 Registrar

			For State Registrar	State of Marylar	•	artment of F		nd Ment		ne . No.2	008		630
		D	1. Decedent's Name (First, Middle, La	ast)					ate of Death	Bade	000	3. Time o	of Death
	Physici /Medic		Jonathan Hope	Cosby					Month Iarch	Day 15	Year 2008	6:55	Р м
	Examin		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, o	r Location of	Death			nty of Death		
, A				land Hospital		Clinto				Pr	ince G		
	Funeral		, , , , ,	Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min. (A	ate of Birth Month, Day, Yo		Cour	**	
L	Director		176-52-5643 Usual Residence of Decedent	48	113.			Ma	r 6, 1	960	Pen	nsylva	nia
	/land ow at		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					1	0d. Inside C	ity Limits
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	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13. \	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify) Puerto Rican	Yes or No-		Race - Americ Black, White,		
20	s afte , or i	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give		1 □ Yes 2X No			,			ack	
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ğ	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last	")			18. Mother'	's Name (Firs	st, Middle, Ma				
<u> </u>	wuld b Mentg arked	To	Russell Cosby					Janet	Wilder				
0	12 should be filed within 'h and Mental Hygiene. 7 Is marked other than "i rraumatic event, ihe Med		19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number	or Rural Rou	ute Number, C	ity or To	wn, State, Zip	Code)	
ž,	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. The first and marked other traumatic avent, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	2	Janet Wilder (E. Edger				<u> </u>			
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Dallillor	t. Pa rtmen rtant: rjury		4 □ Donation 5 □ Other (Speci	fy)		Hills Co			2008	Phi	ladelp	hia,	PA
ס	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai		21. Signature of Funeral Service Lice	nsee	S	. Name and Addre picer-Mu.	llikin	Funer	al Hom	es			
Fig.	(E. J.)		23a, Part1, Enter the diseas, or com	oplications that caused the deat	th Do not ent	000 N Dul	Pont P	kwy. N	ew Cas	tle,	DE 19	720 Approxima	ıte.
	Physician		23a. Part1. Enter the disea +, or com shock, or heart failure. List only Immediate Cause (Final		0.00		19, 50011 05 0	ardido or resp	piratory arrest	9		Interval Be Onset and	tween
	/Medical		disease or condition resulting in death)	a. LIVER Due to (or as a consequence)	PAIL(11CE							
	Examiner			LIDNEY		LURE							
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000	cate be executed by sician and the burial-transit	E E		Due to (or as a conseq									
2	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d DIABETE	S MG	LITUS							
Y	death certifica attending ph I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy					024	Date of delive		
בֿ בֿ	death e atter	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		lEctopic pregnancy Other <i>(specify)</i> _	у			250.	Month	Day	Year
)	t the by the	Physician/Med	9 🗆 Unknown	9□Unknown									
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	cate h	S						1	performe I∐ Yes 2.2		death?	2□ No	
	/sician; The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Tau		of Death (Che	eck only one)				
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.	al or safter	Certification:	4 ☐ Homicide determined	building, etc. (Specil	(y)				City or Town, S		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	71207
	To the hospital of Attending Physician: The within 24 Hours after death. To the Funeral Birector: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Pt	nysician: To the best of my kno	owledge, death	occurred at the tir	me, date and	place, and d	lue to the caus	se(s) and	manner as s	tated.	
-	the h	ledical	Unity .	miner: On the basis of examina and manner stated.	auon and/of inv			occurred at	tne time, date	e and pla	ce, and due to	the cause	(S)
i	70 COLL	Σ	29b. Signature and title of certifier			29c. Licens					gned (Month,		
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1)		30. Name and address of person who				A	(a.1) :1:			25711	_	
	Sta	te	SISOM OSIA, 619 31. Date filed (Month, Day, Year) MAR 2 0 20	32 Registrar's Signa	ature /	210 200	OX	17 40.	LL N	(1)	2074		
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,	Physicia /Medic Examin	a
	Funeral Director	

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 14, 5:14 A M 2008 March Ruth Z. Cooper 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Chevy Chase
If Under 1 Year If Under 24 Hrs. Brighton Gardens Montgomery 8. Date of Birth (Month, Day, Year) May 25, 19 6. Sex Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🖺 F 91 Poland 218-52-5556 1916 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1XYes 2 No Director MD Chevy Chase Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20815 U.S.A. 5555 Friendship Blvd. Rm. 610 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 MWidowed 4 □ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Writer Short Stories 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Barry Zeidner Lena Mora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Byron S. Cooper - Son 3406 Q. St. NW Washington, DC 20007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns. 3/16/2008 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc •1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aortic Stenosis /Medical Due to (or as a consequence of): **Examiner** Valvular and Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) upon M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ace Lipson, MD 1120 19th Street NW Suite 20 Washington, DC 20036 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 19 Registrar 2008

Physician	
/Medical	
Examiner	

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "natural", or flams 23s or 28a-f ahow any injury or other treumatic event. The Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Medical Certification: To Be Completed by Physician/Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: Attar this cartificata has baan signad by the attanding physician and complately filled in by the funaral diractor, page 2 should ba datachad for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

	= State Registrar	Ce	ertificate	of Death		F	leg. No.		
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
an al	IVO	CHIAPPINI				MARCI		2008	710 AM
er	4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Tov	vn, or Location	of Death		4c. Count	y of Death	
	CRESCENT CITIES CENTER	?	RT	VERDALE			PRIN	ICE GE	EORGES
	Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Y	ear If Under	24 Hrs.	8. Date of Birth	1		place (State or Foreign
	219-35-7236 ^{1∑M 2□ F}	87 Yrs.	Months D	ays Hours	Min.	Month, Day	, 1920		TALY
	Usual Residence of Decedent								
	10a. State 10b. County	10c. City, Town or	Location					1	0d. Inside City Limits
ţ	MD. PRINCE GEORGES		RIVER	DALE					1 Yes 2□No
lred	10e. Street and Number		10f. Zip Co	de			10g. Citizen of	What Cour	ntry?
٥	4409 EAST WEST HWY			20737			Τ'n	CALY	
era	11. Marital Status 12. Was Dec	cedent Ever in U.S. 13	3. Was Decedent	of Hispanic Ori	igin? (Spec	cify Yes or No-		ice - Americ	can Indian,
Ξ	Armed F	orces? 2X) No		Cuban, Mexicar		Rican, etc.)	Bla	ack, White,	etc.
þ	3 Widowed 4 □ Divorced If Yes, G Year or I		1 ☐ Yes 2X	No Specify:			Speci	fy:	HITE
ted	15. Decedent's Education		cedent's Usual O				16b. Kind of E		
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BeC	17. Father's Name (First, Middle, Last)	,		18. Mothe	er's Name	(First, Middle,	Maiden Suma	me)	
To B	VASCO CHIA	APPINI			ADA		BANCH	HERI	
-	19a. Informant's Name/Relationship (Type, Print)		iling Address (S	treet and Numbe				-	Code)
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	20a. Method of Disposition	20b. Place of Dis	position (Name	of .		ate	20c. Location		
	1 ☐ Burial 2 ② Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	rematory or other		2 10	2000	DIVEDD	\ A T I''	MD
	21. Signature of Funeral Service Licensee		S CREMA		3-18-		RIVERD		
	2/10// Chamburan	D 1100001	22. Name and A CHAMBER	S FUNER	ĂL HO	ME & CI	REMATOR	UUM, F	P.A.
	23a. Part1. Enter the disease, or complications that	M00091	5801 CL					MD. 2	20/3/ Approximate
	shock, or heart failure. List only one cause on	each line.		-		~			Interval Between Onset and Death
	Immediate Cause (Final disease or condition	ten oschen	ofice	And lol	vasa	u lar L) 15-BI	86	YEROS
		(or as a consequence of):							•
_	Sequentially list conditions, b.								
lne	Sequentially list conditions, fary, learning to immaniate cause. Enter Underlying Cause (Disease or injury	(or as a nonsequence of):							
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by	Part II. Other significant conditions contributing to	-	underlying caus	e given in Part I	١.				he cause of death?
ted	Dinbety mel					1 L Y	es 2□No	3 ∐ Prob	pably 4 dunknown
ple	Atrial Fibrilla	tion				24a. Was a	sv	prior to co	psy findings available mpletion of cause of
ОП	Dementia					perfor	med?	death?	-
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Medical Certification; To Be	examiner? 1 Tes 2 No Hospital: 1	Inpatient 2 ER/Outpati	ent 3 DOA	Cther: 4 DA	ursing Hom	ne 5 ☐ Resid	ence 6 🗆 Ot	her (Specif	(y)
ü	27. Manner of Death 28a. Date	of Injury 28b. Time		Injury at Work?		8d. Describe h			
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iffic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place built	e of Injury - At home, farm, s ling, etc. (Specify)	street, factory, of	fice	21	8f. Location (S City or Tow	treet and Num	ber or Rura	al Route Number,
Seri	Thomas Built	iling, etc. (Specify)				City of Yow	n, State)		
ial (29a. Certifier 1 Certifying Physician: To th	e best of my knowledge, de	ath occurred at t	he time, date ar	nd place, ar	nd due to the o	ause(s) and m	nanner as s	tated.
edic	(Check only 2 Medical Examiner: On the sone)	ner stated.	investigation, in	my opinion, dea	ath occurre	d at the time, o	late and place	, and due to	o the cause(s)
Ž	29b. Signature and title of certifier	0		cense number		- 1	29d. Date sign		
	Ta Clina	me		018	52	_ /	MARCI	1415	2008
	30. Name and address of person who completed cau	se of death (Item 23a) (Type	e, Print)				.,		
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te		Registrar's Signature	1		-				
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DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 13 2008 ar 1:00a м Mary Cacoulidis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Bedford Court Nursing Center Silver Spring 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/26/1924 9. Birthplace (State or Foreign Social Security Number **Funeral** 576-36-3621 Days Hours 1 □ M 2 🔀 F 84 Hawaii Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h Count 10d. Inside City Limits 28a-f show at MD a or 28a-f sh Montgomery Silver Spring 1 ☐ Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? death with 3700 International Drive 20906 USA items 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ed other than "natural", or iten event, the Medical Examiner Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: Hawaiian 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7; and Mental Hygiene. s marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic ever George Kauahilo Kaiamoku Beatrice 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traum once. 15310 Pine Orchard Dr.#34 Silver Spring,Md Mary Jane Menapace/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation oval from State Gate of Heaven 3/19/2008 Silver Spring, Md 5X Other (Engloymbment 4 □ Donation cens e PHILIPADOS RIMALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the death certificate be executed physician end s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Dav Year 4□Pregnant at time of death 5 Other (specify) 1 TYes 2 TNo Ö been signed by the a should be detached 9□Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Chronic obstructive pulmonary disease 1 Yes 2 No 3 Probably 4 Unknown Cardio vascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform certificate 2X No Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one. 1 ☐ Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending 1 Natural ours after death.

neral Director: A
filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 1 X Certifying Physician: To the period of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated. (Check only one) within 24 To the F 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) March 17,2008 D08381 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Dr. Olney, Md 20832 M.D. Benjamin Avrunin 31. Date filed (Month, Day, Year) egistrar's Signature State 1 9 2008 MAR Registrar

William Chatham

Box 68760,
P.O.
Records,
Vital
Division or

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	II. 12		Registrar 1. Decedent's Name (First, Middle, Las	st)			ertificate of L	Jean	2. Date of De		UUI	3. Time of Death
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,	Examin		4a. Facility Name (If not institution, give	10 1		0:	4b. City, Town, or	Location of Dea	th	4c. Coun	ty of Death	100
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	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or	Location			, , , , , , , , , , , , , , , , , , , ,		10d. Inside City Limits
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_	nd 2 alth a 27 Is r trat		Ruth Chatham - wi			140	3 Emerson	Avenue,	Salisbu	ıry, Maı	yland	1 21801
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dis metery, c	sposition (Name of rematory or other plac	e)	Date	20c. Location	- City or T	own, State
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ŘOŽ	ath cel ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗌 Fetal	death	3 □Ectopic pregnancy				Date of deliv	rery Day Year
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DIVISION	or Attendater death. Director: /	icati	2 Accident investigation 3 Suicide 6 Could not b	0	ırv - At hor	ne. farm.	M 1 1	Yes 2 □ No	28f. Location	Street and Nu	mber or Rui	al Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Lee 8:51 FM reamer Mar 22 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 8, 1938 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Months Hours 70 Yrs **Director** 578-52-2283 Jan. Wisconsin Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 536 Shriner Court 21791 U.S.A. Be Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1956-64 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 model maker machinist naval ordnance lab permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Ray Creamer Catherine Culley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 536 Shriner Ct. Norma J. Creamer/wife Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) All County Cremation 3/24/2008 Sykesville, MD 21. Signati e Juneral Service Ligensee 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760% Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manny of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury s after deau. rai Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P19694 ess of person who completed cause of death (Item 23a) (Type, Print) Maryland Medical Conter 225. Greene St. Baltimore MO 21201 MO State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death М March 0540 27 2008 4c. County of Death Edna Carol Grace Coakley 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number Upper Chesapeake Medical Center Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/29/1931 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Country) Michigan 1 □ M 2 🕱 F 386-28-4245 76 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ¥XYes 2 No Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 901 Barnett Lane Apt. 207 21001 U.S.A. 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norris Smith Jessie Irene Gilchrist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lee Kammerer (Daughter) 849 Erie Street Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition R. A. Ferris & Co. 3/29/08 West Chester, PA 4 Donation 5 Dother (Specify) Title Lice 22. Name and Address of Facility 21. Signatura Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Part Lever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NONST EM Due to (or as a consequence of): and stag Due to (or as a conse vence of) Due to (or as a consequence of)

Physician /Medical Examiner

burial-trar

for use as

page 2 should

Hospital or Attending Physician:

24 hours after death Funeral Director:

To the Hosp within 24 hor To the Fune completely fi

filled in by

Completed by

Be

Certification: To

Medical

Physician

/Medical

Examiner

MD

Director

Funeral

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Funeral

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ortant; if them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

al Hygiene. other than

and Mental I 1 and 2 should be

Health a

permit. Pages 1 an Department of Heali Important: If item 2 any injury or other:

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

5 ☐ Other (specify) 9 Unknown

3 □Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

24a. Was an autopsy performed

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

27. Man of Death 1 Natural

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

stalist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date iled (Month, Day, Year)

APR 02

500 upper 32. gistrar's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 19, 2008 12:14 **EVELYN** В DRIIMMOND AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Hours Days 1 M 2 X 83 Jan. England Director 577-42-7016 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Frederick 1 X Yes 2 □ No MD Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 6905 Chokeberry Court USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White Specify. 3 ☐ Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Artist Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Boulton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia V. Drummond /Daughter 11311 Fieldstone Lane Reston, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Adams-Green Funeral Høme3/21/08 Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 721 Elden St. Herndon, VA 20170 Adams-Green Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SWOOD /Medical Due to (or as a consequence of): **Examiner** wha Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica effer death.

I Oirector Af
d in by the fur filled in by

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State Registrar 29a. Certifier

(Check only

29b. Signature and title of pertifier

7 H Stret Mudusar 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 02 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Frederick Men llospital

29d. Date signed (Month, Day, Year)

tradrick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 10:15 PM Peggy Joyce Edwards 2008 March 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) St. Mary's Hospital
5. Social Security Number 6. Sex St. Mary's Leonardtown Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 2, 1947 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🗙 F Georgia 60 578-60-6857 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 💥 ☐ No Maryland Calvert Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 970 Bowie Shop Road 20639 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Insurance Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clark R. Pope Mildred F. Bacon Pope 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40447 Breton View Dr. Leonardtown, Maryland, 20650 <u>Teresa Ann Long/ Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Resurrection Cemetery March 18, 2008 Clinton, Maryland 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licen --126262 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIL LUNG CANCOR of delivery Year Day hute to the cause of death? 3 Probably 4 □Unknown Vere autopsy findings available rior to completion of cause of eath?

☐ Yes 2☐ No

29d. Date signed (Month, Day, Year)

3-12-08

MID

Physician /Medical Examiner certificate be executed

Physician

/Medical

Director

Completed by

Be

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annea.

Baltimore, Maryland 21215-0036

burial-trar attending physician for use as the buria To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760.

Amands

Examiner Physician/Medical þ Completed P Certification:

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical

State Registrar

Sequentially list conditions, any section immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings ava prior to completion of cause death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?		th (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)

DHMH 17 Rev 1/2001

l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 56096

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

0110

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☑ No

Poland

White

For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3/17/2008 Isaac Frishman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Pay, Year) 3/3/1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**K** M 2□ F 086-34-2592 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County MD Anne Arundel Riva Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3084 Scotsborough Way 21140 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Builder Commercial Development 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wolf Frishman Teible Yona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yona Kelly Daughter 3086 Scotsborough Way Riva, MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/2008 | Annapolis, MD Kneseth Israel 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Suneral Sorvice Licenses 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy signed by the a þ Be Completed

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, cate has been signated bage 2 should b this certificate Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifical director, funeral

	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5 ☐ Other				Month Day Year			
Par	II. Other significant conditions	contributing to death but not res	ulting in the underlyin	g caus	e given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
	(andiovar	eler Bit	last			1 ☐ Yes	2 No 3 Probably 4 Unknown			
_						24a. Was an autopsy performed? 1 Yes 2				
25.	Was case referred to medical	26. Place of Death (Check only one)								
	examiner? 1 ☐ Yes 2 ☐ 06	Hospital: 1 ☐ Inpatient 2.	€R/Outpatient 3□	DOA	Other: 4 Nursing I	lome 5 ☐ Residence	6 □Other (Specify)			
27.	Manner of D Natural 5 ☐ Pending investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred			
	3 Suicide 4 Homicide 6 Could not b determined		ome, farm, street, fac fy)	tory, of	ffice	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)			
29		nysician: To the best of my knominer: On the basis of examinating					(s) and manner as stated. and place, and due to the cause(s)			

29c. License number

State Registrar

Certification: To

Medical

29b. Signature and title of certifier

Date filed (Month, Day, Y

Name and address of person who completed cause of death (Item 23a) (Type, Print) 36 0/0 Year) 8 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland	•	nt of Health and ate of Death		iene 008	10640
	Physici	an	Decedent's Name (First, Middle, Last)	well			2. Date of Deat	h Day Year	3. Time of Death
	/Medi Examir	cal	4a. Facility Name (If not institution, give si		4b. Cit	y, Town, or Location of De	march	11 ZOS	
	Funeral		5. Social Security Number 6. Sex	T. Age (In yrs. Ia	st birthday) If Und	er 1 Year II Under 24 H		9. Birth	nplace (State or Foreign
	Director		239.30.4327 10 Usual Residence of Decedent	M 2/0 F 05	Yrs. Month	s Days Hours M	in. DC 5	1922 Con	NC NC
	anyland ahow	7	10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
`	or 28a-f	lrect	10e. Street and Number	1. D:	101.2	Zip Code	1	0g. Citizen of What Co	1 ☐ Yes 2 No untry?
	ne 23e	Funeral Director	105 Kirk Car	2. Was Decedent Ever in U.S.	. 13. Was Dec	21921	(Specify Yes or No-	14. Race - Amer	ican Indian
980	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or Iteme 23e or 28e-1 ahow event, the Madical Examinar must be multiped at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? secify Cuban, Mexican, Pu 25 No Specify:	erto Rican, etc.)	Specify: B	
21215-0036	n 72 ho s "natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's Us (Give kind of N	sual Occupation work done during most of w	working	16b. Kind of Business/I	ndustry
	filed within Hygiene.		Elementary/Secondary (0-12)	College (1-4or 5+)	Hou	Sewil		trivate	Hone
Maryland	ould be fi Mental H arked otl atic ever	To Be	17. Father's Name (First, Middle, Jac)	DOKS		18. (Mother's N	lame (First, Middle, M	Maigen Sumame)	S
Man	d 2 sho th end t7 is ma trauma		1-a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Addr	ss (Street and Number or	Rural Roots Number	City of Tylin, State, Z	ip Code)
ore,	00		20a. Method of Disposition	1 1000	ice of Disposition (Natery, crematory of	ame of other place)	Date	20c Location - City or	Town, State
Baltimore	rtmen rtant:	-	4 Donation 5 Other (Specify) 21. Sgnature of Funerat Service Lines ser	· 1 191	22. Name	and Address of Facility	MAN FU	New Cus	siu, DE
80	Depe Impo any I		23a Part. Enter the disease, or complie	ations that carse if the death.		BOX 2593	Wilm D	2 1985	Approximate
	Physician	/	Immediate Cause (Final disease or condition	cause on schine.	aru	Arten	1 Dise	-20	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):				
29	nsit	Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	mea of):				
. 60	icate be executed physiclan and s tha burial-transit	I Exa	that initiated events c. resulting in death) Last	Due to (or as a conseque	ince of):				
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Вох	death certifii e attending p d for use as	Physician/M	in the past 12 months2	c. tf yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3 □Ectopic			23d. Date of deli	very Day Year
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Records,	w requires the been signed should be dei	ted by	Tarti. Ottor significant conditions confi	nouting to death out not result	ing in the underlying	cause given in Part I.		pacco use contribute to	
Reco	e law has t	Completed					24a. Was a autops perform	ned?eath?	topsy findings available ompletion of cause of
/ital	iding Physician: Th th. : After this certificete funeral diractor, pag	Be C	25. Was case referred to medical examiner?	to telescope and the		26. Place of D	1 ☐ Yes 2 Death <i>Check only on</i>		2 1 No
of	Phys this ral di	. To	1 ☐ Yes 2 ☐ No Ho		R/Outpatient 3 0			ence 6 Other (Spec	city)
Division of Vital	Attending is deeth.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe no	w injury occurred	
Divi	교육등	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, larm, street, lacto	ery, office	281. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	a Hospital 24 hours e a Funeral etely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my knowledge: On the basis of examination and manner stated.	edge, death occurre in and/or investigation	d at the time, date and pla on, in my opinion, death oc	ice, and due to the ca courred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and titte of certifier		2	9c. License number	1 1 15 12	9d. Date signed (Mont)	Dey, Year)
•			20. Name and address of person who con	pleted cause of death (Item 2	23a) (Type, Print) /	J 1005	6449	3113/	78
	4		31. Date filed (Month, Day, Year)	San Und 11	Wes	High St	Suite	302 E1K+	n MD21921
	Sta Registr		MAR 2 0 20		K Soul				

		For State Registrar	;	State of Ma	aryland		oartmer e <i>rtifica</i> i				ienę (1118	105	1
		1. Decedent's Name (First, Middle	le, Last)							2. Date of Deat		Vans	3. Time of [Death
Physic		Leonard Gallagi	ner							3/16	5/2008	Year	8:17	a ^M
/Med Exami		4a. Facility Name (If not institution		reet and number)			4b. City	Town, or	Location of Death		4c. Cou	nty of Death	1	
		Anne Arundel Me	edica	ıl Center	:				polis		Anne	Arun	de1	
Funera Director		5. Social Security Number 138–34–7531	6. Sex	7. Ag	e (In yrs. la 64	ast birthda Yrs.	y) If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/19/	Year)	9. Birth Cou	place (State or intry) NJ	Foreign
D		Usual Residence of Decedent											tod Issida Cin	et imite
nylan how	_	10a. State 10b. County	'		10c. City	, Town or	Location						10d. Inside City 1 ☐ Yes	
e Ma	cto	MD Anne	Arunc	le1	C:	hurch								XX
ë o ë	Dire	10e. Street and Number					10f. Zi	p Code		1	0g. Citizen	of What Cou	intry?	
ath w	<u>a</u>	1214 Ellicott						2073		- T W No.	14.1	USA Race - Amer	ione Indian	
DESILITIOTE, INIGITY CALLE 13-0030 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at mone.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 42 ② Divorced	ned	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		S. 13	If Yes, spe	ocify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White	, etc.	
72 hours	Completed	15. Deceder	nt's Educa	ation	1	16a. Dec	cedent's Usu	al Occupa	tion uring most of work	kina	16b. Kind o	f Business/l	ndustry	
thin 7	nple	Elementary/Secondary (0-12)	isi grace	College (1-4or 5	5+)	life	. DO NOT	ise retired)	arring those or home	9	-			
M Bed will	Co	10				Bri	.cklay	er				truct	10n	
Viding	Be	17. Father's Name (First, Middle,	Last)							ne (First, Middle, i ine Cast		name)		
ould out warks	2	John Gallagher						(2)				Ct-1- 7	in Code)	
VICE 12 sh h and 7 is m treum		19a. Informant's Name/Relation				1	-		nd Number or Ru				ip Code)	
end teelth m 27		Anna Neild 20a. Method of Disposition	Cc	ompanion	20h P		4 ETT position (Na		Ave. Ch			0/33 on - City or 1	Town State	
mit. Pages perment of the portant: If its y injury or of the portant is the portant in the portant is the portant in the porta		1 ☐ Burial 2 ② Cremation 4 ☐ Donation 5 ☐ Other (3		moval from State	CE	emetery, c tro (rematory`or Cremat	other place ory	3/18	3/2008	Balti	more,	MD	
Dall permit. Depert Import		21. Signature of Funeral Service	License	•					s of FacilityHar					
40500		23a. Part1. Enter the disease, of	0	ations that source	t the death	Do not				Annapoli		2140	Approximate	1
Physiciar		shock, or heart failure. Lis Immediate Cause (Final	t only one	cause on each li	ne.	i. Do not e	0 1 -		g, sucii as cardiac	or respiratory arr	651,		Onset and D	veen
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Examine		Sequentially list conditions	ь											
₽ ∺	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į "	Due to (or as	a conscio	ilitri sanaii								
ecute and trans	Examiner	that initiated events resulting in death) Last	c.	Due to (or as	a consent	ience of):						-		_
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ficate ficate	edical		d.							- V		-		
OX O	Ž	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outcome			- 7-				23d.	. Date of deli	very	
death death d for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live birth 4 ☐ Pregnant a			3 □Ectopic 5 □ Other (s			-		Month	Day Y	'ear
	hys	9 Unknown		9∐ Unknown										
Ords, requires thet	y P	Part II. Other significant condit	ions cont	ributing to death b	ut not resu	ulting in the	underlying	cause give	en in Part I.				the cause of d	
cords wrequires been sign should be	ed									1 🗆 Y	es 2⊡N	lo 3∏Pr	obably 4 Sk	Inknown
law re	Completed by	1								24a. Was a		4b. Were au	topsy findings a	available ause of
The law	E									perfor	med?	death?	2 No	
VICAL MEG ulcien: The lav certificete hes rector, page 2	BeC	25. Was case referred to medic	al						26. Place of Dea	ath (Check only or				
ysician: ysician: ys certific director,	To E	examiner? 1 ☐ Yes 2 ☑ No	Ho	ospital:	ent 2 🗆	ER /Outpa	tient 3 🗆 🗅	Othe	er: 4 🗆 Nursing H	lome 5□Resid	ence 6	Other (Spec	cify)	
og Phy ter this		27. Manner of Death 1 Natural 5 Pend	ina	28a. Date of Inju	ıry ıy Year)	28b. Time Injur	e of	28c. Injury Work	at c?	28d. Describe h	ow injury o	ccurred		
ISION C tranding P death. tor: After I	atic	2 Accident inves	tigation				М	10	Yes 2 ☐ No					10
> A period	Certification:		mined					28f. Location (Street and Number or Rural Route Number, City or Town, State)				ber,		
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To th Withir To th comp	₩ E	29b. Signature and title of certific	er /)			2	9c. License	e number		29d. Date s	igned (Mont	h, Day, Year)	
		Fred The	Vie	~ 1	10			カスツ	1804		3/16/	05-		
المال		30. Name and address of person	n who cor			n 23a) (Ty	oe, Print)		2001	Medical	Parkw	ay		
464		Robert Pe	tor	son n	ND.		+ A n	10		ropely	M	0	21461	
	tate	31. Date filed (Month, Day, Yea		32. Rest	rar's Signa	iture				U				
Regis		MAR 1	ل لا كال	100	eve	D.	Good							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 13 2008 3:00 A M Rachel Gray /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Crofton Convalescent & Rehab | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, One) | Min. | Sept 13 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year, 1922 Maryland 85 Yrs. 215-28-5263 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State items 23s or 28s-f show 1X Yes 2 □ No Annapolis Maryland Anne Arundel Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 633 Tripp Creek Ct. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? th and Mental Hygiene. 7 Is marked other then "netural", or item treumatic evant, the Medical Exerting. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Self Employed 12th 1yr 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental Hitant: If item 27 Is marked oth jury or other treumatic even Be Joseph F. Abrims Eva Elizabeth Rice ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 633 Tripp Creek Ct. Annapolis, Md. 21401 Brewer E. Gray Sr(Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Maryland Veteran 3-24-08 Crownsville, Md. MMame Remarks of Scill Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Jarry 13, Beese MOO483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician monery /Medical sequence of) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician requires that the death certificate be Physician/Medical as the l 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ů 28d. Describe how injury occurred 28c. Injury at Work? filled in by the funeral 27. Manner of Death Certification: Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature ape Highway Sw Olan Burne MD 2106/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schu 208 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 15 2008 1:34A M March Katherine Mae Groves 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PG Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Couin V A 1 □ M 2 🛣 F 02/14/1935 229-38-7959 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1X TYes 2 □ No Indian Head Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20640 12 Beth Court 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No 3X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clinical Secretary Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Preston Edward Lawhorne Ida Mae Bonsher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Carson Groves PO Box 440 Marbury, Maryland 20658 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterens Cemetery March 25,2008 Che

22. Name and Address of Facility Huntt Funeral Home
3035 Old Washington Road
Waldorf, Maryland 20601 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee m01262 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): psis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland Hygiene.

than

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the I

Baltimore, Maryland 21215-0036

the burial-trar attending physician for use as the buria ed by the a signed k page 2 s has Hospital or Attending Physician: The 24 hours after death. certificate

Be Completed by Physician/Medical

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous 9 □ Unknown	al death 3□Ectopi	c pregnancy (specify)	_	23d. Date of delivery Month Day Year
Part II. Other significant conditions of Yencel Fail U	ontributing to death but not res	ulting in the underlyin	ng cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed	
25. Was case referred to medical examiner?			26. Place of D	eath (Check onl one	
1 Yes 2 No	Hospital: 1 Inpatient 2 □]ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 Other (Specify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac ffy)	ctory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
29a. Certifier (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and pla ation, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, Day, Year)
			D0058797		3115/08

20744

MD

WASHINGTON

State

MAR 2 0 Registrar

31. Date filed (Month, Day, Year)

LIVING-STON RO, SUITETOI 32. Refistrar's Signature

2008

Funeral Director: stely filled in by the

24 To the **Physician**

/Medical

Examiner

Funeral

Items 23a or 28a-f show 'natural", or Items 23a or 28a-f shov dical Examiner must be notifled at

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural," or file any file marked other than "inatural," and injury or other traumatte event, the Medical Examines Completed own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marshall Yeider Stella Corrigan Yeider 19a. Informant's Name/Relationship (Type. Print)
Linda Piercy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14325 Elton Drive, SW Cumberland MD 21502 daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Restlawn Memorial Gardens 3/31/2008 MD LaVale 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23e Fart Lefter the ni-east or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE CEREBROVASCULAR ACCIDENT 10 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 Ves 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No ours after death.

neral Director: /
filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25,2008 D33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUPTA, SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Sieve & Sparte DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Oneida Goss MARCH 27, 2008 15:15 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ALLEGANY WMHS - MEMORIAL CAMPUS CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Apr 11, 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □**X** Yrs. MD 84 215-16-4362 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14325 Elton Drive, SW 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ 🔥 Specify: 3 X Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker

		State of Mary 1 - State Registrar		artment of Hortificate of L			ene g. No. 2008	10645
Physic /Medi		1. Decedent's Name (First, Middle, Last) Lena Mary George				2. Date of Death Month March 2	Day Year	3. Time of Death 9:00 P м
Exami Funeral		4a. Facility Name (If not institution, give street and number) Kline Hospice House 5. Social Security Number 6. Sex 7. Age (In 1978-07-2478 1 D M 2 🗷 F 9.	n yrs. last birthday) 3 Yrs.	4b. City, Town, or Mount If Under 1 Year Months Days	Location of Death L Airy If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 19,	4c. County of Death Freder: 9. Birthp Court 1915	ick lace (State or Foreign sylvania
Maryland f show jed at	tor	Usual Residence of Decedent	c. City, Town or Lo	cation Frederick		raidi 19,		0d. Inside City Limits 1 □ Yes 2 ☒ No
h with the 23a or 28a st be notif	al Director	10e. Street and Number 2524 Five Shillings Road		10f. Zip Code 2170	01	10	og. Citizen of What Cour United St	•
faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.
Maryland 21215-0036 td 2 should be filed within 72 hours af th and Mental Hygiene." tr Is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, OMEMAKET	ation uring most of worki	ing	16b. Kind of Business/In	-
/land	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Pio Marconi			18. Mother's Name	aleri		
and 2 sho ealth and 1 n 27 ls me her traums		19a. Informant's Name/Relationship (Type. Print) Melanie Quinn / Daughter	2524	Five Shi	llings Ro	ad, Fred	City or Town, State, Ziplerick, Mary	land 21701/
Baltimore, Marylar permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enones.		1 ☐ Burial 2 Micremation 3 ☐ Hernoval from State 4 ☐ Donation 5 ☐ Other (Specify)	Silbaugh Va	osition (Name of matory or other place ult & Buria	L 20	n 29, 08	20c. Location - City or To Uniontown Pennsylva	n, ania
Balti permit. Departr Importe any inji			1433		rch Street,	Frederick	sford P.A Fune k, Maryland 21	701 Approximate
Physician /Medical Examiner		resulting in death) Due to (or as a c	alignamt l		g, such as cardiac (or respiratory arre	st,	Interval Between Onset and Death
ficate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the con						
4 0 10	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
dS, P.O. uires that the de isigned by the all the detached is	b	Part II. Other significant conditions contributing to death but r	not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	oacco use contribute to t es 2⊠ No 3□ Pro	he cause of death?
Vital Record: sician: The law require certificate has been si	Completed					24a. Was al autops perforr 1 Yes 2	y prior to co ned? death?	opsy findings available impletion of cause of
Vita slcian certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Deat		e) ence 6 X Other <i>(Spec</i> i	M Hospice
Division or Vital Records, P.O. Box to the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Certification: To	27. Manner of Death 1 X Natural 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury (Month, Day Y	(ear) 28b. Time of Injury	of 28c. Injur Worl	y at ⟨? Yes 2 □ No	28d. Describe ho	ow injury occurred reet and Number or Rui	·
Divi		29a. Certifier (Check only 2 Medical Examiner: On the basis of e	xamination and/or it					
To the within 2 To the complete	Medical	29b. Signature and title of certifier	d	29c. Licenso D4309		2	9d. Date signed (Month, March 27,	
	tate	30. Name and address of person who completed cause of deal Saeed A. Zaidi M.D. 801 T 31. Date filed (Month, Day, Year) 32. Registrar's	Collhouse	Avenue,	#E1, Fred	erick, N	Maryland 21	701
Regis DHMH 17 Rev 1/	tarib	31. Date filed (Month, Day, Year) APR 0 2 2008	S. Apare	IGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#5, 15, 16a, 16b State of Maryland / Department of Health and Mental Hygiene Registrer per FH 3/18/08 CM AACO HEALTH DEPICERTIFICATE of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** nande GUSTAVO /Medical cility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F al Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreigg **Funeral** Months Days Year Yrs Director None Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show if Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28e-f ehov other traumatic event, the Modical Examin er must be notified at 1 Yes 2 □ No Directo 15 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62 -140 Completed by Funeral M 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes EX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 2 🗆 No Specify Specify: 4 □ Divorced Panic Hispanic 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant None Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Enrique ၉ SUSTANO ueroa intos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any Injury or other tra 00 62 W and 20b. Place of Disposition (Narth of cemetery, crematory or other place) 20c. Location City or Town, State Date 20a. Method of Disposition 1 Burial 2000 remation 3 Removal from State 3/19/2008 Baltimore, MD Metro Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, F.A. 21. Signature of Funeral See 0 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) erue /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1 Yes after death.

Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: P 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Certification: Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i filled Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filled (Month, Day, Year) / MAR 1 8 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Derorty HERSCH. 9:22 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Grace startord MERONAL JAVES (the ford tospioni de If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
Months Days Hours Min. Aug. 19,1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Maryland 1 ☐ M 2 🖾 F Yrs. 81 Director 214-22-2267 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 27 is marked other then "naturel", or iteme 23s or 28e-1 ehow treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 U.S.A. ll Meadow Lark Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marifal Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Eight Year's Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fit and Mental H William A. Emmel Dorothy M. Kromm ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Edward K. Hirsch, Sr. (Husband) 11 Meadow Lark Drive, Port Deposit, Maryland 21904 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if ite
eny injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 03/22/08 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Perryville, Maryland 21903-0700 23a. Part1. Enfer the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EPTIC fmmediate Cause (Final Physician disease or condition resulting in death) カイシ /Medical Due to (or as a consequence of): Examiner Supportially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-translt (01) 8571VE)tegrT resulting in death) Last Due to (or as a conseque e of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? Be Completed by ARI) 10 MYCDATH isch emic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 certificete 20 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one Medical Certification: To

Division of Vital Records,

Attending Physician: Director: filled in by within 24 hours after To the Funerel Dire ŏ Hospitel completely

examiner? 1 ☐ Yes 3 ☐ No	Hospital: 1 Inpatient 2 □ E	R/Outpatient 3 DO	OA Other: 4 Nursing H	lome 5 ☐ Res	idence 6 Other (Specify)	
27. Manney of Death ↓ Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of 2 Injury M	lec. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined		ne, farm, street, facfor	y, office	28f. Location City or To	(Street and Number or Rural Route Numbe wn, State)	;
29a. Certifier Check only 2 Medical Example (Check only one)	nysician: To the best of my know miner: On the basis of examination and manner stated.	riedge, death occurred on and/or investigation	at the time, date and place, in my opinion, death occu	e, and due to the urred at the time	cause(s) and manner as stated. , date and place, and due to the cause(s)	
29b. Signature and fittle of certifier	1 mo	290	DGG3U	2	29d. Date signed (Month, Day, Year)	

20.

State Registrar

PATEL 31. Date filed (Month, Day, Year) MAR 2 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500



		For State Registrar	State	of Marylan		artment of F rtificate of		d Mental H	lygiene Reg. No. 2	08	10648	
	à.	Decedent's Name (First, Middle	e, Last)					2. Date of Month		V-ar	3. Time of Death	_
Physi /Med			Ok Yo	Han				March	Day 14	Year 2008	6:20 p M	
Exam		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	or Location of D	eath	4c. Count	y of Death		_
		Holy Cross Ho	spital			Si	lver Spri	ing	Mo	ontgome	ery	
Funera	1	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 I	Hrs. 8, Date of			place (State or Foreign	-
Directo		046-72-3777	1 □ M 2 🗷 F	91	Yrs.	Months Days	Hours		r 15, 1916		th Korea	
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e Ma Sa-f s	읝	Maryland Mont	gomery			P	otomac					
or 24	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
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r deg	Funeral	11. Marital Status	12. Was De Armed I	cedent Ever in U Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No- 14. Ra	ce - Americ ick, White,		
amin		1 Never Married 2 Marr	If Yes, 0			1 ☐ Yes 2 K No	Specify:		Speci	fy:		
UNITE INTERIOR	d by	3 x Widowed 4 □ Divorced	Year or	Dates:	10- P	1			105 Vind -4.5		Asian	
"nat	Completed	15. Deceden (Specify only highe	t's Education st grade completed	d)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of E	susiness/in	dustry	
withir she.	Ę	Elementary/Secondary (0-12)	College	(1-4or 5+)	ine. i	Homem				Own Hon	ne	
ING 21215-UU36 be filed within 72 hours after death with the Maryland tital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle,	(ast)			Homen		Name (First, Mid	dle, Maiden Surna			-
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Aaryland 2 2 should be filed v and Mental Hygie is marked other raumatic event, tt	၉	Unknown 19a. Informant's Name/Relations	Kang		10h Mailir	a Address (Ctrast	l and Number o		mber, City or Town	Ctata Zia	Codel	_
Maryla d 2 should th and Mer 7 is marke traumatic			, , , , ,								Code)	
or Health		David Han - So 20a. Method of Disposition	n	20b. F		sition (Name of	sn Lane,	Date Date	ryland 20		own. State	_
Pages ment of l		1 X Burial 2 ☐ Cremation			cemetery, crei	natory or other pla				•		
Baltimol permit. Pages Department of Important: If It any injury or or		4 Donation 5 Other (S		Ga	and the second second	aven Cemet	CONTRACTOR OF THE PARTY OF THE	3/18/2008	Silver S	Spring,	Maryland	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exam		21. Signature of Funeral Service	licensee /	•	I	2. Name and Addre Iines-Rinal	di Funera	al Home, I	nc.			
		One Florid Federation disease of	1/vm	t coursed the door			_			ng, Man	ryland 20904 Approximate	
		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause or	each line.	n. Do not em	er the mode of dyl	ng, such as car	rdiac or respirator	y arrest,		Interval Between Onset and Death	
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BOX eath cer attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1 □ Live	outcome pf pregna birth 2 Peta	al death 3	Ectopic pregnanc	у			ate of delive Ionth	ery Day Year	
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_ ⊢ at a	Completed								erformed? es 2 K No	death? 1 ☐ Yes	2 □ No	
Or VITAL I Physician: Th this certificate ral director, pag	Be (25. Was case referred to medica examiner?						Death (Check on	nly one)			_
Of \ Physical ral dire	은	1 ☐ Yes 2 🔀 No			ER/Outpatier	" JU DOY		ng Home 5□R	lesidence 6 🗆 Ot	her (Specia	fy)	
- 0 0	Ë	27. Manner of Death 1 ▼Natural 5 □ Pendir	/4.4.	te of Injury onth, Day Year)	28b. Time o Injury	f 28c. Inju Wo	ıry at ırk?	28d. Descri	be how injury occu	rred		
VISION Attending r death. ector: Afte	ati	2 ☐ Accident investi	gation				Yes 2 No					
DIVISION I or Attending after death. I Director: Afte	IĔ	3 Suicide 6 Could 4 Homicide determ	nined 28e. Pla bui	ce of injury - At ho Iding, etc. <i>(Specil</i>	ome, farm, str <i>fy)</i>	eet, factory, office		28f. Locatio City or	n (Street and Num Town, State)	ber or Rur	al Route Number,	
DIVI e Hospital or At 1.24 hours after of e Funeral Direct letely filled in by	Certification:		1,41									
Hospital Hospital Hospital Funeral I	edical	(Check only 2 Medical	Examiner: On the	basis of examina					the cause(s) and n me, date and place			
To the Hosp within 24 ho To the Func completely f	ledi	one)	and ma	anner stated.								_
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10		alan 4	R Le	gal.	ms		D52261		March	14, 20	008	
1		30. Name and address of person	(6		*, * * * * * * * * * * * * * * * * * *							
		Alan R. Segal				llver Sprin	g, Maryla	and 20906				
	tate	31. Date filed (Month, Day, Year)	2000	Registrar's Signa	ature	anti a						
Regis	strar	MAR 19	2008	March &	5 /5							_

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth Helen Horz March 23,2008 7:45 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 9,1925 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F West Virginia 236-22-5907 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 300 Sunflower Drive Apt. 220 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: ģ Maryland 21215-003 3√2 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 12 should be filed w h and Mental Hygier 7 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Stanley **McBee** Ilena Mae Householder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is Sharon L. Beichler 922 Rock Springs Road, Bel Air MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Hagerstown Crematory 3/26/08 Hagerstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lies 95 Union Street 25411 #M0052 Melsley-Johnson F. Home Inc. Berkeley Springs, WV #M0052 Felsley-Johnson F. Home Inc.; 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PNEUMON 14 ASPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami and Due to (or as a consequence of) attending physician by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ō 4☐Pregnant at time of death 5 Other (specify) the 9 ☐ Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? URINARY TRACT INFECTION 1 Yes 2 No 3 Probably 4 Unknown Completed CHIRONIC OBSTRUCTIVE LUNG DISENSE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy performed? within 24 hours after deam. To the Funeral Director: After this certificate I completely filled in by the funeral director, pag DEHYDRATION 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Valo Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier Andul Nowheave up. 29c. License number 29d. Date signed (Month, Day, Year) D08097

5 State

Registrar

31. Date filed (Month, Day, Year)

ANPRON NOWHKOWSKI MD. 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

35 FULFORD NE, BOLAIR, MD 21014

			For State	State of Maryla	•				200	0 10050
		-	Registrar 1. Decedent's Name (First, Middle, Las	**)		ertificate of L	Jean	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an	Clifton Johnson	,				Month	13 2008	10:55P M
	/Medic		4a. Facility Name (If not institution, give			4b. City. Town, or	Location of Death		4c. County of De	
	Examin	ier	162 Brownswood	,		Annapo			Anne A	rundel
	Funeral		5. Social Security Number 6. S				If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. Bi	rthplace (State or Foreign Country)
	Director		214-34-4390	₹ M 2□ F	69 Yrs.	Working	TIOGIO IVIIII	Nov 12	2 1938 Ma	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	Manyl: f sho ied al	ē	Maryland Anne A	rundel A	napo	lis				1 ⊈Wyes 2 □ No
	r 28a- notif	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	th with	al D	162 Brownswood	Rd.		2140	1		USA	
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	. 14. Race - Am Black, Wh	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menth Hygiene. If Health and Menth Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ∐Yes 2 ∰ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		- "	lack
²	thour atural	edt	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occup	ation		16b. Kind of Busines	s/Industry
מ	hin 72 9. an "na Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Giv life.	e kind of work done of DO NOT use retired	during most of wor l)	king	Annapoli	S
7	ad wit	Som	12th	0		Forman			Dirt Con	tractors
2	be filk tal H) d oth event	Be	17. Father's Name (First, Middle, Last, Otho Johnson St					, , , , , , , , , , , , , , , , , , , ,	Maiden Surname)	
2	2 should be filed withi and Mental Hygiene. is marked other thar aumatic event, the M	L _O			106 840	ling Address (Ctrost	Cora W		or City or Town State	Zin Code)
	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Carl Johnson (Se			B Heartwo			er, City or Town, State, Ld , Md . 2	
ת ב	tem 27 i		20a. Method of Disposition			position (Name of emails of of other place		Date	20c. Location - City of	
Daltillion	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State M		al Garde		9-08	Annapoli	s, Md.
2	permit. Departm Importal any Inju		21. Signature of Funeral Service Licer	<u> </u>					uary, P.A	
<u>۵</u>	8 3 1 6 6		Jany B. Re	ese moc483		B21 West	St. An	napolis	s, Md. 21	401
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not e		1 .			Approximate Interval Between Onset and Death
p.	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ner	afocel	lular	(avci)	nolly	SMOS
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					3,
r	*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	quence of):					
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
Š	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):					
0/00,	cate be executed physician and the burlal-transit	dical	•	d						
O XO	certific ding p	/Med	IF FEMALE:	23c. If yes, outcome pf pregi	nancy				004 Patracka	- Daniel Control
0	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	☐Ectopic pregnancy☐ Other (specify)	1		23d. Date of d Month	Day Year
Ċ	the d	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
Ļ	The law requires that the death certific ale has been signed by the attending p page 2 should be detached for use as	by PI	Part II. Other significant conditions	ontributing to death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
coras,	equire en siç ould b	ed t						10,	Yes 2 2 1No 3□	Probably 4 Unknown
i i	law r las be	Completed						24a. Was	osy prior t	autopsy findings available completion of cause of
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\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		ent 3 DOA Oth	or.	ath (Check only c		
วั	Physer this eral di	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpation 28b. Time	of 28c. Injur	4 Nursing F		dence 6 Other (Sp now injury occurred	pecify)
5	nding rth. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2∐No			
2	Atternation of the section of the se	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At building, etc. (Spec	home, farm, s	street, factory, office		28f. Location (3 City or Tow	Street and Number or	Rural Route Number,
5	ital or rs afte ral Di	Cerl								
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		ysician: To the best of my kr niner: On the basis of examin						
	o the	Med	29b. Signature and tiple of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
)	F > F 8		. J. Llo	uul U)		19838		3/14/2	2008 Unapolis, had
	500	lu	30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	e, Print)	n Roct	71 (112	D. Av	Mac Ocalis 1/1
	142		Stuaut E.	selonicu,	MO	90	U Dest	Just	ra. Isv	ricepois, nat
	Sta		31. Date filed (Month, Day, Year)	2008 32. Egistrar's Sign	nature	hard .				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar

		1. Decedent's Nam	ne (First, Middle	e, Last)							Month	Day	Year	3. Time of Death
Physicia /Medica		William 1	N. Kauf	mann Sr.							MAYC	n 13	2008	2022 M
Examine	-	4a. Facility Name (If not institution	n, give street and	number)			4b. City, Town					nty of Death	1.
aja.		Me	MOHI	al Ho	Spit	al			STON				Alloc	ot
Funeral Director		5. Social Security N 218-09-12		6. Sex 12 M 2 □		e (In yrs. la 90	st birthday) Yrs.	If Under 1 Yes Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da	y <i>year)</i> 91.7	9. Birth Cou	place (State or Foreign ntry) D
		Usual Residence o	of Decedent											10d. Inside City Limits
yland now at		10a. State	10b. County			10c. City,	Town or Lo	cation						1 ☐ Yes 2 ☑ No
Mar a-f sl	흕	MD	Queen	Anne		Que	ensto	wn						71
h the	<u>ie</u>	10e. Street and Nu	ımber					10f. Zip Code	e			10g. Citizen	of What Cou	ntry?
h wit	Funeral Director	1140 Che	ston La	ne					1658				SA	
deat mms.	ner	11. Marital Status		Armer	1 Forces?	Ever in U.S	. 13.	Was Decedent of If Yes, specify C	f Hispanic (uban, Mexi	Origin? (Spean, Puert	pecify Yes or No o Rican, etc.))- 14. F	Race - Ameri Black, White	
after or Ite mine	교	1 Never Mar		ried 1553	es 2 □ ľ . Give	No WWI	II	1 ☐ Yes 2 X ☐ N					ecify: Wh	nite
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ed w lygiel rt, th		12	/First Middle	(cot)				WIICI	18. Mo	ther's Nan	ne (First, Middle	. Maiden Suri	name)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name Henry Ka		Lasij					Ka	theri	ne True	lieb		
shou ind M s mar		19a. Informant's N	Name/Relations	ship (Type. Print)							ıral Route Numb			ip Code)
alth a 27 is		David A.	Kaufma	ann	Son		1140	Chesto	n Lan	e Que	enstown			
s 1 a of Hear of he of he of he		20a. Method of Dis	sposition		01-1-		ace of Disperent	osition (Name of matory or other	olace)		Date	20c. Locatio	on - City or	Town, State
Page lent c nt: If ry or		1 Lx Burial 2 4 ☐ Donation	UCremation 5 ☐ Other (3	3 □Removal f Specify)	rom State	Mary	land	Veteran	s Cem	3/18	3/2008	Crown	sville	e, MD
mit. Sartır Sorta inju		21. Signature of	Funeral Service	Lisunsee						cilityHar	desty F			, P.A.
permi Depa Impo any ii	ı i	Vai	1) M	1				2 Ridge			Annapoli		21401	
y		23a. Part1. Enter shock, or he	the disease, o	r complications to	nat caused on each li	d the death ine.	. Do not en	ter the mode of	dying, such	as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician	0.4	Immediate Cause	(Final	00	Jours	00.00	Ω.						1	Onset and Death
/Medical		resulting in death		a. Du	e to (or as	a consequ	ence of):							
Examiner		0		b. De	rica	rdin	151	1480	2				-	
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ding Physician: The law requires that the day After this certificate has been signed by the funeral director, page 2 should be detached	Physi	Part II. Other sign		ions contributing	to death l	hut not resu	ulting in the	underlying cause	aiven in Pa	art I.	23e. Did	tobacco use	contribute to	the cause of death?
res th	δ	Part II. Other sign	illicant condi	ione contributing	to doda.						1	Yes 2	No 3∏Pr	robably 4 Unknown
requi	ted										24 144) 41: 10/2 m a.	the section of the se
law lasb	a Ple										24a. Wa	s an 2 opsy formed?	prior to death?	utopsy findings available completion of cause of
The zate h	Completed										1□ Yes		1 ☐ Yes	2 □ No
Attending Physician: r death. ector: After this certifica by the funeral director, i	Be	25. Was case ref examiner?	erred to medic	al Hospital:					Othor		ath (Check only			
hysi this c	ပ္		No		1 Inpat			ent 3 DOA	4 L	Nursing	Home 5 Re	sidence 6 L e how injury o		cify)
ing P	on:	27. Manner of De 1 Natural	5 ☐ Pend	ing	Date of Inj (Month, D	ay Year)	28b. Time Injury	M 28C.	Injury at Work? 1 □ Yes - 2	n □ No	Zou. Describe	s now injury or	ccurred	
tend eath. tor; / the fi	cati	2 ☐ Accident 3 ☐ Suicide	inves 6 ☐ Could	tigation	Diago of in	sium, At ho	me form s	treet, factory, of		2 🔲 140	28f Location	(Street and N	Jumber or R	ural Route Number,
or At fter d Direct in by	Certification:	4 ☐ Homicide	datas	minod 200.		etc. (Specify		treet, lactory, or				own, State)		
oital ours al		On Carriffor	Courtifi	ing Physician: 1	o the bee	t of my kno	wledge de:	ath occurred at t	he time dat	te and plac	e, and due to th	e cause(s) an	nd manner a	s stated.
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Medical	29a. Certifier (Check only one)_	2 Medica	al Examiner: On	the basis manners	of examina	tion and/or	investigation, in	my opinion	, death oc	curred at the tim	e, date and pl	ace, and du	e to the cause(s)
To the I within 2 To the I complet	Med		nd title of certil		mainer s	stateu.		29c. Li	cense numb	oer oer		29d. Date s	signed (Mon	th, Day, Year)
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		30. Name and ac	141/	T ON	1010	death /lta-	23a) (Tun-	Print)	0	7 1	1)	1 101	<u> </u>	7 200 6
MINI		30. Name and ad	ouress of perso	on who completed	IG I	Mean (nem			rive	Rose	1: A: N	10 21	211	
XLIOLA	ate	31. Date filed (M	lonth, Day, Yea	r)	32. G gis	trar's Signa	ture ()	11810	1100	- OF 8			711	
Regist		·	MAR 1	8 2008	Street	we.	B.	porte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 2008 8: 25 PM Kreiner Robest /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth Hours Min. May 3, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year
Months Days 9. Birthplace (State or Foreign **Funeral** Pennsylvania 167-14-4451 86 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3514 Foxhall Drive 21035 United States death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours efter YYYes 2 □ No 1939— fryes, Give Year or Dates: 1945 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White þ ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Master Machinist Pharmaceuticals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Amelia Ruhl ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Kreiner, Jr. / Son 3514 Foxhall Drive Davidsonville, Maryland 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 nent of P 1 ☐ Burial XXCremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 5 Other (Specify) Baltimore Crematory 3/18/2008 4 Donation Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Cloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat Aspiration P.
Due to (or as a consequence of): Physician Preumonia 24 hours disease or condition resulting in death) /Medical Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Noknown athros close tre Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Congestive page 2 s certificate has PETIDHENAL VAJILIAN dISPAIL 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death | Check only one examiner' Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending Naturat 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

9/160

State Registrar

Mark Janchie 31. Date filed (Month, Day, Year) MAR 1 8 2008

29b. Signature an Ltitle of certifier

200 1 modical Parkusy Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

License number

6

29d, Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)
MAR 1 9 2008

Physician /Medical Examiner

Funeral Director

Please	•		delible Ink. Ensure Al	-	•	
1 - For State Registrar	State of Marylan		artment of Health and M rtificate of Death		iene 2008	3 10653
1. Decedent's Name (First, Middle,	_ast)		-	2. Date of Dea Month	th Day Year	3. Time of Death
Jeanne Elizabe	eth Krams				13, 2008	10:05 p M
4a. Facility Name (If not institution, g	live street and number)		4b. City, Town, or Location of Death		4c. County of Dea	ath
Laurel Regiona	l Hospital		Laurel		Prin	ce George's
Social Security Number 6	Sex 7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth		rthplace (State or Foreign ountry)
218-84-0735	84	Yrs.		Oct. 17		shington, DC
Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Lo	neation			10d. Inside City Limits
Maryland	Montgomery		er Spring			1 □Yes 🛠 🙀 No
10e. Street and Number			10f. Zip Code	1	0g. Citizen of What C	ountry?
12801 Old Colu	mbia Pike, #126		20904		USA	
11. Marital Status	12. Was Decedent Ever in U.		Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
1 Never Married 2 Married				HICAN, etc.)	Black, Whi	
3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify:Wh	Lte
15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	l .			D	
12 17. Father's Name (<i>First, Middle, La</i>	st)	ı sal	es Representative 18. Mother's Name	e (First. Middle	Retail Maiden Surname)	
Webster Edward				, , ,	,	
19a. Informant's Name/Relationship		40h 14-'''	ng Address (Street and Number or Run	Van Sic		7in Codo), 2000 4
Elizabeth Jeanne		1	12801 Old Columb			, , = 0501
20a. Method of Disposition		Place of Dispo	osition (Name of Marc	Date ch 19,	20c. Location - City o	r Town, State
1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State		TT 0 '		Silver Spr	ing, Maryland
21. Signature of Funeral Service Lic		22	2. Name and Address of Facility		STIVEL OF	ing, nary rana
23a. Part1. Inter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	implications that caused the deathly one cause on each line. a. Stroke Due to (or as a conseq	h. Do not ent	500 University Blv ter the mode of dying, such as cardiac			ring, Md 20901 Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a conseq	uence of):				
that initiated events	С					
resulting in death) Last	Due to (or as a conseq	uence of):				
•	d					
IF FEMALE:						
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3[□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions		ulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Heart Failure	3			1 □ Y	es 2∐No 3∐F	Probably 4 🔼 Unknown
		-		04- 144	0.41- 144	, , , , , , , , , , , , , , , , , , ,
		_		24a. Was a autops perfor 1∐ Yes	sy prior to med? death?	utopsy findings available completion of cause of s 2 No
25. Was case referred to medical			26. Place of Deat			
examiner? 1 ☐ Yes X [X] No	Hospital: 1 X Inpatient 2	ER/Outpatier	Other		ence 6 □Other (Sp	ecify)
27. Manner of Death	28a. Date of Injury	28b. Time o			ow injury occurred	
Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year) ion	Injury	Work? M 1 ☐ Yes 2 ☐ No			
3 Suicide 6 Could not 4 Homicide determine		i ome, farm, str fy)	reet, factory, office	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
29a. Certifier 1 Certifying	Physician: To the best of my kno	owledge, deat	h occurred at the time, date and place,	and due to the c	ause(s) and manner a	as stated.
(Check only 2 Medical Ex	aminer: On the basis of examina and manner stated.	ation and/or in	vestigation, in my opinion, death occur	red at the time, o	late and place, and du	ie to the cause(s)
29b. Signature and title of certifier	1 //	2	29c. License number	2	9d. Date signed (Mor	oth, Day, Year)
> //manal/	MINU		D53235		March 17,	2008
30. Name and address of person wh	to completed cause of death (Item	n 23a) /Tuna	Print\			
Darryl Hill MD			enue, Laurel, Mary	land 2	0707	

State Registrar

Medical

legistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 406 PM KNapp ZOOS 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Saltimore Harbor Hospital If Under 1 Year | if Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months Hours Min. Director with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a once. 1 ☐ Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .5. Funeral death Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1963-74 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Statu Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ۾ 3 Widowed 4 Divorced MITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 24 MAGOTH BRITGE ENNY KNAM 20a. Method of Disposi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State REMATORY 4 □ Donation 5 ☐ Other (Specify) Daugherty Family Funeral Home And Cremation Center, P.A. Part1. Enter the disease of complications that could not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one section each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mania /Medical Due to (or as a consequence of) **Examiner** ceil Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Trobably 1 ☐ Yes 2 ☐ No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2□No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20146 1 Impatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOUT 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frin Licutensten 3001 S. Honover Street Baltimore Moryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

David	Rhode	Lawrence

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	F	- For State Registrar		Certific	cate of	Death				Reg.	No.	J () (
Physiciar edical Examin	er	1. Decedent's Name (First, Middle, David R. Lav	vrence						2. Date of Month Marc				3. Time of Death 1215 hrs
- Carlo		 Facility Name (if not institution, 308 Forbes Street 	, give street and number)		4	4b. City, Towi Annapol		cation of	Death		4c. County of Anne Aru		
Funeral Director		140 60 7444		n yrs. last bi 48	irthday) Yrs		Year Days	If Under Hours		,	мм/dd/үүүү) б , 1959	Cou	nplace (State or Foreign ntry) nnsylvania
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Tow	n or Locati	ion						\neg	10d. Inside City Limits
Maryland 28a-f show 1 at once.	ا ا	Maryland Anne A	Arundel					polis	s 	Lie	- CM		1 XXYes 2 No
the Mary	Director	10e. Street and Number 308-K Forbes S	Street			10f. Zip Co		401		10g.	Citizen of Wha		try?
	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Everified Armed Forces?						n? (Specify Yes Puerto Rican, e		14. Race - White,		an Indian, Black,
그 호티	by Fu	3 Widowed 4 X Divor	1 Yes 2 X	No	1	Yes 2XX	No .	specify:			Specify:	Whi	te
2 hours:	ted b	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade complete College (1-4 or 5+)	eted) 16a	during m	ost of working	g life. D		nd of work done use retired)	1	6b. Kind of Bus		
036 vithin 72 hou ene. er than "nat Medical Exa	Completed		4		Au	to Par					Automol	oile)
21215-003 and be filed within marked other the event, the Med	မ်ို့ မြ	17. Father's Name (First, Middle, L Albert Lawrence	·				18		Name (First, M talie R		,		
		19a. Informant's Name/Relationshi James Lawrence				,					er, City or Town		Zip Code) NJ 07716
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If item 27 is n injury or other traumatic	ŀ	20a. Method of Disposition		20b. Place		ition (Name o			Date		20c. Location -		
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation 5 Other Spe			Linco	ln Cre							Maryland
Ball permit Depart Impor injury		21. Sign of Funeral Service L	icensee Z	L							lor Fu Annap		Al Home s, MD 21401
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.		not enter t	he mode of d	ying, st						Approximate Interval Between Onset and Death
⊂xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Oxycodone and Due to (or as a consequ		ol Into	oxicatio	n						Death
	<u>•</u>	Sequentially list conditions, if any, leading to immediate	b	ence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):									
xecuted n and l - transit		X UNPENDED	d	7.28a-f	f ø878	4/10/08	3 amh	<u> </u>					
68760, certificate be ex nding physician se as the burial		IF FEMALE:	23c. If yes, outcome			1, 20, 00				-	23d. Date of		
Box 687 re death certific the attending I	sician	23b. Was decedent pregnant in the past 12 months?	4 Pregnant at tim	ne of death	- =	etal death ther (Specify,	3	Ectopic	pregnancy		Month	D	Day Year
J. Box r the death c by the atten ached for us	튄	1 Yes 2 No 9 Unkr	9 Olikilowii	ut not result	ting in the t	underlying ca	use giv	en in Par	t I. 23e	e. Did toba	acco use contri	bute to	the cause of death?
s, P.O. nires that to signed by d be detac	희								_ [1				pably 4 Unknown
of Vital Records, ig Physician: The law requin the this certificate has been s' meral director, page 2 should I	Completed		.	_						a. Was an autopsy _ perform	ped? d		topsy findings available completion of cause of
tal Rection: The certificate ector, page	င့်	25. Was case referred to medical	1			26.	Place o	of Death (1 Check only one	Yes 2	No 1	✓ Ye	es 2 No
f Vita Physicia rr this ce	ğ P	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		/Outpatient		,	other ₄	Nursing Home		esidence 6 v		: Scene
on of ending P ath. or: After the funera	ţ	1 Natural 5 Pendi)	b. Time of I			es 2 X	ŀ	30120110	w injury occurre		
Division of Vital Records, P.O. Box 68760, 10 Spital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stell filled in by the funeral director, page 2 should be detached for use as the burial - transiting in by the funeral director, page 2 should be detached for use as the burial - transiting the page 2 should be detached for use as the burial - transiting and a spital page 2 should be detached for use as the burial - transiting and 2 should be detached for us	Certification:	77	28e. Place of Injury	y - At home,	, farm, stre		fice bui	ilding, etc	28f. Loc or Annat	cation (Str Town, Sta	reet and Number te) 308 For AA Co. I	r or Ru rbes VD 2	St., Apt. K
To the Hospital within 24 hours To the Funeral completely filled	edical C	29a. Certifier 1 Certifying Phy	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, c	death occu	rred at the tin	ne, date oinion, c	e and place death occ	ce, and due to t	he cause((s) and manner	as state	ed.
E 3 E 8	B	29b. Signature and title of certifier				l	icense).C.M	number .E.			29d. Date signe March 26, 2		nth, Day, Year)
169		30. Name and address of person v				et, Baltimo	ore M	 (D 2120	n1	1			
Sta	ate	31. Date filed (Month, Day, Year) MAR 2		Signature			, IV						
Registr	rar	MAR 2	O ZUUO	U 1	. 4	certe							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-0656 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day March 13, 2008 4:15 P ^M Mildred G. Lozowick 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2X F 102 May 12, 1905 Illinois 342-40-1590 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 6121 Montrose Road U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) City of Chicago Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hannah (Unascertainable) Charles Gutstadt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4301 Massachusetts Ave., NW #7003 Washington, DC Susan L. Rolnick - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 ■ Removal from State 4 Donation 5 Dother (Specify) Waldheim Jewish Cem. 3/17/08 Forest Park, Illinois 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, Md 20852 23a. Part1. Enter the disease, or complications that causes, he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ıral", or Items 23a or 28a-f show | Examiner must be notlfied at

'natural"

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical

. Pages 1 and 2 should be file iment of Health and Mental Hytant; If Item 27 is marked oth

Directo

Funeral

Completed by

Be

P

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans attending physical for use as the b

P.O.

Division or Vital Records.

certificate has been si rector, page 2 should within 24 hours after death

To the Funeral Director:
completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant condition	ns contributing to death but not re		g cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 17. Natural 5 Pending 2 Accident investign	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		home, farm, street, fact	cory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, tte)

29c. License number

TKOJSE

018084

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

29b. Sigrature and title of certifie

19 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

TARK PAIGE LEFF TOWNSHIP CONTROL OF THE PROPERTY OF THE PROPER				For State	State of M	arylan					and M		•	0000) 1 (1657
TART PAICE LEFF Seamon Hill Road Seamon Hill R				Registrar 1. Decedent's Name (First, Middle	e, Last)		Oe1	uncat	e oi L	Jealii				2000	3. Time	of Death
The part of the pa				TARA PAIGE 1	LEFF							03/04/	2008	/ Year	3:4	9 A M
TOTAL DISCRETA CONTROL OF THE CONTRO	0			-)		4b. City,	Town, or	Location of	of Death					
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The purpose of the pu				123-68-4678							24 Hrs. Min.	8. Date of Bir (Month, Da 12/25/	th ay, Year) 1984	9. Bird Co New	ountry)	e or Foreign
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Mark Leff Linda Schlesinger Linda Schles		th the or 28; e not	Jirec	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of What Co	ountry?	
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Mark Leff Linda Schlesinger Linda Schles		er dea items ner m	nue		Armed Forces	?	S. 13. \	Was Dece If Yes, spe	dent of His cify Cuba	spanic Ori n, Mexicar	gin? (Spec n, Puerto F	cify Yes or No Rican, etc.))-			•
Mark Leff Linda Schlesinger Linda Schles	36	rs afte	oy F		If Yes, Give	No		1 ☐ Yes	2 X No	Specify:				Specify: V	Vhite	
Mark Leff Linda Schlesinger Linda Schles	8	2 hou atura	ted				16a. Deced	dent's Usu	al Occupa	ation			16b. Ki	ind of Business	/Industry	_
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Physician Medical Physician Medical Physician Physicia	ē,	s 1 all of Heal	l i	20a. Method of Disposition		1 0	lace of Dispo	sition (Nar	ne of	-						
Physician Medical Physician Medical Physician Physicia	<u>ii</u>	Page nent c				9 1 .		-			3/06	/2008	Pin	elawn,	NY	
Physician Medical Physician Medical Physician Physicia	alti	epartr epartr ports ny Inju		21. Signature of Furleral Service	Licensee		Da	2. Name ar	d Addres	s of Facilit	erg M	iemoria	ı1 Ch	apels.	Inc.	
Physician (Micclas) Micclass Micross Micclass Micclass Micclass Micclass Micclass Micross Micclass Micross Micclass Micross Micclass Micross Micclass Micross Micro	-	20 E # 9		the			111	70 R	ockvi	11e	Pike,	Rock	vil1	e, MD 2	20852	
Company Continue	-24.5				r complications that cause only one cause on each l	d the death line.	n. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory a	rrest,	111	Approxir *Interval Onset a	nate Between nd Death
Secure this place of the past 12 months? The past				disease or condition	_a Bila	tera	O F	neun	non	au	vill	1 ma	nu	a zyje	nen	
Cause. Enter Indentying Cause.					Due to (or as	a consequ	uence of):							OV		
Due to (or as a consequence of): Due to (or as a consequence of):	>	Eq.	ē	Sequentially list conditions, it any, leading to immediate		s a consequ	uence ol).									
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DHMH 17 Rev 1/2001

ORIGINAL

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			State of Maryland / Department of Health and N	Mental Hygie	ene	
			Registrar Certificate of Death	Reg	J. No. 2 0 0 8	-10658
	. Physici		1. Decedent's Name (First, Middle, Last) Linda B. Mosberg	Month	Day Year 2, 2008	6:55 P M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. City, Town, or Location of Death Arnold		4c. County of Death	
			544 Bay Green Drive Arnold 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)
	Funeral Director		005-38-1805 1 M 2 XF 64 Yrs. Months Days Hours Min.	(Month, Day,) Jan. 10	,1944 Mai	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryli -f sho lied at	tor	MD Anne Arundel Arnold			1 □Yes 2 No
	death with the Maryland ms 23a or 28a-f show r.rnust be notified at	Funeral Director	10e. Street and Number 544 Bay Green Drive 10f. Zip Code 21012	100	g. Citizen of What Co USA	untry?
	r deat tems	nner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
7 6	ING Z IZ I 3-VU30 be filed within 72 hours after death wit tal Hygiens and attem "natural", or items 23a of other than "natural", or items 23a of event, the Medical Examiner must b	by Fi	1 □ Never Married 2 M Married 1 □ Yes 2 M No If Yes, Give 1 □ Yes 2 M No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: \vec{W}	hite
W	D-UU30 72 hours af "natural", or edical Exami	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina I -	6b. Kind of Business/l	-
' &	within within than "than "he Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Baltimore Medical Ce	Washington nter
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3	laryland 2 should be filed and Mental Hygi is marked other sumatic event, t	To Be	Edmund Beaulieu Anna Bo	ouchard		<u>,</u>
0	INICYICALO INICALO INI	ľ	19a. Informant's Name/Relationship (Type. Print) William H. Mosberg III/Husband 19b. Mailing Address (Street and Number or Ru 544 Bay Green Drive			
-)	Heal Heal		J		Oc. Location - City or	
3	Pages Pages nent of I		Bunal 2 Nicremation 3 Hemoval from State	008 Ba	altimore,	Maryland
2	Daltimore, permit. Pages 1 a Department of Hee Important: If item any Injury or othe		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P. 495 Gov. Ritchie Hw	A. Severi y, Severi	na Park Fu na Park, M	neral Home D 21146
::=::::::	-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequency of):			0.10
	Examiner		Due to (or as a consequency of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events C. Due to (or as a consequency of): Due to (or a sons quence of) Due to (or a sons quence of) August Manual Cause of Cause (Disease or Injury or Injury of Cause (Disease or Injury	nes,		31
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	It The	laure	34
	U, execu an and rial-tra		resulting in death) Last C. Due to (or as a consequence of):			9/
2	cate be executed physician and the burial-transit	dical	d			
		/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy		23d. Date of del	iverv
3	The law requires that the death certifute has been signed by the attending agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
1	S that I	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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The same	Kecords he law requires e has been sigr sge 2 should be	Completed		24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings available completion of cause of
7		ပ္ပို	25. Was case referred to medical 26. Place of Dea	1 Yes 2.	No 1 ☐ Yes	2 No
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7	LIVISION OF I or Attending Phy a er death. Director: After this in by the funeral d	ficati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined logical and (Spacific) and (Spacific) farm, street, factory, office	28f. Location (Str	eet and Number or Ri	ural Route Number,
No E	LIVI alorAi saerd al Direc	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	, State)	
T.	LIVISION To the Hospital or Attent within 24 hours are death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control on the basis of examination and/or investigation, in my opinion and occurred at the time, date and place control of the basis of examination and occurred at the time, date and place control of the basis of examination and occurred at the time, date and place control of the basis of examination and occurred at the time, date and place control of the basis of examination and occurred at the time, date and place control of the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the basis of examination and occurred at			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician MARTIN FREDERICK 1:15 RAYMOND P.M 2008 */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Feb 12, 1935 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F Months Days Hours Min. 73 215-32-8346 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Maryland Carroll Taneytown 1 ¥Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò Pages 1 and 2 should be filed within 72 hours after death with **USA** 21787 81 George Street items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No 1958-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: white 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Year or Dates: 'natural", 1960 er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Railroad Man Railroads 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic even Raymond W. Martin Margaret Brewer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 81 George Street, Taneytown, MD 21787 permit. Pages 1 and 2 s Department of Health an Important; If item 27 is any Injury or other trau Phyllis Ann Martin, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Keysville Union Cem | 3/22/2008 Keymar, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 136 E. Baltimore Street, Taneytown, MD 21787 -Tare 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINUTES **Physician** /Medical ARTERIOSCLEROTIC CARDIOVASCULA) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending physical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ been signe should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has birector, page 2 s autopsy perform 2 No To the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 🔲 Inpatient P ≥ ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours fter death. neral Director. filled in by the f 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier (Check only one)

within 24 hours

To the Funeral (WJL STIVA

State Registrar

31. Date filed (Month, Day, Year)

WILLIAM R.

29b. Signature and title of certifie

ONE KINGS LINTHICUM M.D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

manner stated.

TANEYTOWN

08

MD

29d. Date signed (Month, Day, Year)

21787

DR.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12 2008 Waller Albert Morris March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death La Plata Charles 101 Westly Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days 1**X** M 2□ F Yrs 10, 1934 Virginia 73 April 216-30-2768 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1**)**(_)(Yes 2 □ No La Plata Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 101 Westly Drive 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 🖈 No White Specify Specify. 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) A&P Grocery Store Produce Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold H. Morris Cora E. Copher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6915 Retirement Rd. La Plata, Sherron Kline/ Daughter Maryland, 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery March 17, 2008 Brentwood, MD. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Juneral Service muiz62 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vocardia disease or condition resulting in death) Due to r as a consequence of): lipidemin Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 robably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 21 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner** Examiner aw requires that the death certificate be executed

ortant: If I

permit. Page Department of Important: If any Injury or once,

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

Division or Vital Attending Physician:

The

After this certificate

spital or Attendli ours after death. neral Director: A filled in by the fu

within 24 hours a

DB3

Medical

State

Registrar

Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If Item 27 Is marked other than

Director

Funeral

2

Completed

Be ဂ္

/Medical

attending physician and for use as the burial-trar n signed by the a ld be detached f funeral

Physician/Medical Completed by Be Certification: To

1 ☐ Yes 2 Y No Manner of Death

1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

(Check only one)

29a. Certifier

6 ☐ Could not be Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D005 8686

29d. Date signed (Month, Pay, Year) , 2008 March 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Branch Ave Temple Holls Md 6104

Naugen 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 2 0 2008

32. Registrar's Signature

		For		State	of Maryla					and M	lental Hy	giene	e	0.0	1 (200
		State Registrar				C	ertificat	e of l	Death			Reg. No	s. 4. U	08		100
Physicia	ın	Decedent's Name (2. Date of De Month	ath Da 1	ay	Year		of Death
/Medic				h Malayth							March			008	3	:45 P M
Examin	er	4a. Facility Name (If n		-	umber)		4b. City,		Location o			40	c. County o			
				g Street	7 4-4 (10	- look bi-46-4-) If Lindo	Silv 1 Year	er Spr	_	O Data of Dia	-	Мо	ntgome		
Funeral		5. Social Security Nun		6. Sex 1 ☑ M 2 ☐ F		rs. last birthda Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year		9. Birthpia Count	ry)	e or Foreign
Director		216-37-92 Usual Residence of D			73	3					June 27,	193	4		La	os
and t			0b. County		10c.	City, Town or	Location							10	d. Inside	City Limits
Mary f sho	ō	Maryland	Mon	itgomery				Silv	er Spr	ino					1 🗆 Y	es 2⊠No
h the Maryland r 28a-f show i notified at	Director	10e. Street and Numb		.08001	1		10f. Zij		or opr		Т	10g. Ci	itizen of W	hat Count	ry?	
3a or 3		1/.2	1 Coles	burg Stree	+				2090	5				Laos		
ms 2.	Funeral	11. Marital Status	.i cores	12. Was De	cedent Ever in	n U.S. 1	3. Was Dece	dent of H			ecify Yes or No Rican, etc.)	-		- America		
r iter	ᆵ	1 Never Married	1 2⊠ Marri	Armed F ed 1 ☐ Yes	2 🔯 No					, Puerto	Rican, etc.)		Black	, White, e	tc.	
urs a al", o Exam	Š	3 ☐ Widowed 4	Divorced	If Yes, G Year or	live Dates:		1 ☐ Yes	2X No	Specify:				Specify:		Asian	
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thin 7 e. Med	ple.	Elementary/Second			(1-4or 5+)	- life	ve kind of wo . DO NOT u	se retired	iumg mosi ()	OI WUIK	mg					
filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	6					Factory	Work	er				Po	ultry		
al Hy al Hy oth	Be (17. Father's Name (Fi	irst, Middle, I	_ast)					18. Mothe	r's Name	e (First, Middle,	Maide	n Surname	3)		
Ment Ment arked	To E		Xieng	Nanh						Phac	Vongdeu	ane	2			
2 sho and is ma		19a. Informant's Nam	e/Relationsh	ip (Type. Print)		19b. Ma	iling Addres	(Street	and Numbe	er or Rur	al Route Numb	er, City	or Town, S	State, Zip	Code)	
and ealth n 27 her tr	-			ong - Wife					Street		ver Spri					
of H of H if iter		20a. Method of Dispos		3 □Removal fron	1	o. Place of Dis cemetery, c	position (Na rematory or	me of other plac	:θ)		Date	20c. L	ocation - (Dity or Tov	vn, State	
Pag ment ant: I		4 □ Domation 5				ort Linc	oln Cre	mator	у (03/20	/2008	Bre	ntwood	l, Mar	yland	
permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bones.		21. Signature of Fund	eral Service L	icensee			22. Name a	Rinald	i Fune	ral F	Home, Inc		-			
207 2 2		Tas	wh	The			11800	lew Ha	mpshir	e Ave	enue, Sil	ver :	Spring	, Mary	land	20904
*		23a. Parri. Enter the shock, or heart	is a se, or allur. List	complications that only one cause on	caused the de each line.	eath. Do not e	enter the mo	de of dyin	g, such as	cardiac	or respiratory a	rrest,			Approxin Interval E	Between
Physician		Immediate Cause (Findisease or condition	nal	a	Pancrea	itic Cano	er								Onset ar	id Death
/Medical		resulting in death)		Due to	o (or as a cons	sequence of):					· -					,
Examiner		Sequentially list cond	itions.	b												
p ti	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj	ediaté ring	Due to	o (or as a cons	sequence of):										
ecute and trans	cam	that initiated events resulting in death) Las		C	. /									_		
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icate be executed physician and s the burial-transit	edical			d										-		
= -		IF FEMALE:		23c If yes o	utcome pf pre	ananov										
attendatter	ian	23b. Was decedent p in the past 12 m		1 ☐ Live	birth 2 F	etal death	B Ectopic p		,				23d. Date Mon	of deliver th	ry Day	Year
the de	Physician/M	1 Yes 2 □ I	No	9□Unk	gnant at time o nown	orgeath :	5 ☐ Other (s	респу)								
The law requires that the death ate has been signed by the atter bage 2 should be detached for u		Part II. Other significa	ant conditio	ns contributing to	death but not r	resulting in the	underlying	ause give	en in Part I.		23e. Did t	obacco	use contri	bute to the	e cause o	of death?
sign d be	p										10	Yes 2	2⊠ No	3 ☐ Proba	ably 4	□Unknown
w require been signature	Completed										0.4= 14/==		0.41- 14			
The lav	I I										24a. Was auto	psy ormed?	p	rior to comeath?	npletion o	gs available of cause of
											1□ Yes	2 ≦ N		Yes	2□ No	
sician: certific rector,	Be	25. Was case referred examiner?		Hospital:				Oth	er.		h (Check only o					
this aldi	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	,	1	Inpatient 2	2 ER/Outpat		JA	4 L Nu		me 5 A Resi			1 6 2)	
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death ctor: / the	ical	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could n	ot be	ce of injury - A	t home, farm.					28f. Location (Street a	and Numbe	er or Rural	Route N	lumher
I or Attendi after death. Director: A I in by the fu	Certification:	4 ☐ Homicide	determi	buil	ding, etc. (Spe	ecity)	,	,,			City or To			. o, rigidi		
spita ours neral		29a. Certifier 1	☑ Certifying	g Physician: To th	ne best of my I	knowledge, de	ath occurred	at the tir	ne, date an	d place,	and due to the	cause(s) and mar	nner as sta	ated.	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical			Examiner: On the												e(s)
To th To th Somp	Me	29b. Signature and tit	le of certifier	′ ^			29	c. Licens	e number			29d. D	ate signed	(Month, E	Day, Year	7)
2		\	- 14	/\/				D	35635			Ī	March	18, 20	008	
5	-	30. Name and addres	s of person v	vho completed car	use of death (I	tem 23a) (Typ	e, Print)									
		Tagant 17	'anlan	M D 1011	1 Deines	Dhilin	Daviaro	Cuito	327	01200	Maryla	nd o	0832			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAR 1 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Katherine B. Marvil 3 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SALISBURY
If Under 1 Year | If Under 2 Hrs.
Pays | Hours | Min. WICOMICO WICOMICO NURSING Hom Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. 91 **Funeral** 1 □ M 2 🛣 F Oct. 9, 1916 215-10-5377 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Md Wicomico Salisbury Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 900 Booth Street by Funeral 21802 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Pages 1 and 2 should be Elwood Bell Alice Higgins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug Marvil (nephew) 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Odd Fellows Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2008 Laurel, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

(I) NO (1) (1) VE Hannigan, Short, Disharoon Funeral Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ab d 21 No 1 □ Yes certificate 1□ Yes 2☑No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death.

uneral Director: A

sly filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in 24 hours ...
o the Funeral Direct
...alv filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

514

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 0 2008

TELON STORE DK STUSBURY MD21804

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** William Martin MARCH 28 2008 9:57 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORTAL HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Yea Mar 21, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours 1 → M 2 □ F 1926 MD 82 Director 216-22-5549 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Cumberland MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 719 Arundel Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ **X**o Baltimore, Maryland 21215-0036 Specify Specify: 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Martin Heating owner/operator permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 Is marked other any Injury or other traumosts. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Rizer Martin Carl W. Martin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17201 4100 Shatzer Street Chambersburg PA daughter Teresa Giffin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Kaurial 2 Cremation 3 Removal from State 4/1/2008 MD St. Mary's Cemetery Cumberland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Furjeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Concer una Year /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown ancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 X Natural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Months Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avale, Maru Khanna 1221-E National Highway

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Carto

2. Registrar's Signature

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, 句

		For State Registrar		State of Ma	aryiano / L		riment of F		na Men		ene g. No.2	008	10664
Physici /Medic		Decedent's Name		^{st)} ther Mary	Marti	n				Date of Deat Month Brch	Day	2008	3. Time of Death 2:54 A. M
Examir				e street and number) wship Home			4b. City, Town, or Hagerst		Death			unty of Deat	
Funeral Director	15200	5. Social Security Nu 218–50–37	umber 6. S	*	(In yrs. last bii	rthday)_ Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. D	Date of Birth Month, Day, ril 18		9 Birthplace (State or	
ryland how		Usual Residence of 10a. State	10b. County		10c. City, Tow								10d. Inside City Limits
the Ma 28a-f s notified	recto	MD.	Washin	gton	На	gers	10f. Zip Code			10	Na Citizen	of What Co	1 □Yes 2 No
th with 23a or 1st be	al Di		Huyett L	ane			21740)				3.A.	unity.
rurs after dea al", or items Examiner mu	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. No		Vas Decedent of H Yes, specify Cuba □ Yes 2 No	ispanic Origir in, Mexican, I Specify:	n? (Specify Puerto Rica	Yes or No- n, etc.)		Race - Ame Black, White ecify: Wh	e, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Special Special 15. Decedent's Edify only highest grandary (0-12)	lucation ide completed) College (1-4or 5		(Give k life. D	ent's Usual Occup kind of work done o O NOT use retired emaker	ation during most o)	of working			of Business/	ndustry	
	To Be Co	17. Father's Name (/		J. Diller					•	st, Middle, M Mart		rname)	
2 shou and M		19a. Informant's Na			I		Address (Street						lip Code)
ages 1 and nt of Health: If Item 27		Donald H. Martin/Husband 12349 Huyett Lane Hagerstown, Md. 21740 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Reiff Mennonite Church 3/29/08 Cearfoss, MD.											
permit, Pa Departme Important any injury once.		4∐Donation 21. Signature of Fur				Cen	netery Name and Addres 45 S. C	s of Facility	Zimm	erman	And	Son Fi	neral Home
				plications that caused one cause on each lin			r the mode of dyin						Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (F disease or condition resulting in death)		Due to (or as a	MEN	of):		-Or	616	n			4 YEARS 20 YEARS
	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.								X0 KULZ			
eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d	. Date of deli	very Day Year
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions continuous to death but not resulting in the underlying cause given in Part I.								the cause of death? obably 4 ☐Unknown			
	Completed								-	24a. Was ar autops perforn 1∐ Yes 2	y	prior to death?	topsy findings available completion of cause of 2 ☐ No
ysician: iis certific director,	o Be	25. Was case referre examiner? 1 Yes 2 N		Hospital:	nt 2□ER/Ou	utpatient	3□ DOA Othe	25"		eck only one		Other (Spec	n/6/)
ding Pr	ition: T	27. Manner of Death 1 Natural 2 ☐ Accident		28a. Date of Injur (Month, Day	v 28b.	Time of Injury	28c. Injur Worl		28d.	Describe ho			<u></u>
To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubuilding, etc	ry - At home, fa c. (Specify)	arm, stree	et, factory, office			ocation (Str City or Town		umber or Ru	ral Route Number,
To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifler (Check only one)	1 ☑ Certifying Ph 2 ☐ Medical Exan	ysician: To the best on the basis of and manner sta	examination ar	e, death nd/or inve	occurred at the tir estigation, in my o	ne, date and pinion, death	place, and o	due to the ca	ause(s) and ate and pla	d manner as ace, and due	stated. to the cause(s)
To the within To the Comp	Me	29b. Signature and	itile of certifier	182	NUC)	29c. License 29c. 29c. 29c. 29c. 29c. 29c. 29c. 29c.		f	29 M	od. Date si	igned (Mont) H 26	n, Day, Year) , 2008
5		30. Name and addre	ess of person who	BECK	eath (Item 23a)	(Type, P	rint) /	10 M	elic	al Co	mpu	IS R	21742
Sta	ite	31. Date filed (Ment	Ray (20!		ur's Signature	Son	A. D	7	,	, , , ,	- 🔻		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. STATE OF MARY PARTY DEPARTMENT OF Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Katherine Myers Evelyn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland 1115 Kentucky Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 24, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🖫 F 217-10-1461 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. In: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Cumberland 1x Yes 2 □ No MD Allegany ıral", or items 23a or 28a-f sh Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 1115 Kentucky Avenue Funeral 14. Race - American Indian, ed other than "natural", or items: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Coning Dept Textile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Dawson Hockaday Sydney Hockaday 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1115 Kentucky Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Liola Norman Myers 1115 Kentucky Avenue husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 4/1/2008 MD Flintstone 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause og each line. Approximate Interval Between Onset and Death Immedi e Cause (Final disea e or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Be Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes r this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient te of Injury onth, Day Y NO No 1 ☐ Yes 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Teath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMBERIAMO, MD 31. Date filed (Month, Day, Year) Registrar's Signature State APR 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** ()/45 M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 109 Beverly Avenue Edgewater If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/19/1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours 1 □ M Washington, DC Director 578-05**-**6093 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland , and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show ited Examiner must be notified at 1 ☐ Yes 2 X No Edgewater Maryland Director Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21037 USA 109 Beverly Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺ No White Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Me Ical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Contract Specialist 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Henning William Halley မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sr Department of Health and Important: If item 27 Is n any injury or other traun once. 206 Poplar Ave., Edgewater, MD 21037 Cecelia M. Rinehart/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Kalas Crematory 3/18/08 Edgewater, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Livense 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6 WC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical F FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) n signed by the a ld be detached fo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **₽** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performe certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident r death. the 1 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

requires that the death certificate be executed Division or Vital Records, P.O. Physician: within 24 hours after death To the Funeral Director: ò Hospital the

Baltimore, Maryland 21215-0036

Box 68760,

31. Date filed (Month, Day, Year) Registrar

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

EENSE HIGHWAY ANNAPOLIS MIDZIYO

Ammended box #8 per Phys. 3/17/08 Carroll County WSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Ragistrar	State o	of Maryland / Dep Ce	artment of H			erie () () ()	10667
			1. Decedent's Name (First, Midd	fle, Last)				2. Date of Death		3. Time of Death
	Physici		Raymond Newel	1				Month March 14	Day Year 4 • 2008	9:50 A, M
8	/Medic Examin		4a. Facility Name (If not institution		mber)	4b. City, Town, or	r Location of Dea		4c. County of De	
4	Exami		St. Joseph's	Provincia	1 House	Emmits	burg		Freder	cick County
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hr			irthplace (State or Foreign Country)
15	Director		217-26-7760	1 ☐ M 2 🔯 F	78 Yrs.	Months Days	Hours Min	Ton 15		aryland
	ס		Usuel Residence of Decedent		70			Tuan.	70 110	
	ytan how		10a. State 10b. Count	y	10c. City, Town or L	ocation				10d. Inside City Limits
	Ma 	15	MD Fre	derick	Emmitsb	urg				1 ☐ Yes 2 ☐ No
	n th	lre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	deeth with the Maryland me 23a or 28e-f ehow f.mat be notified at	al	333 South Set	on Avenue		21727			U.S.A.	
	8 E	ner	11. Marital Status		edent Ever in U.S. 13. proes?	Was Decedent of H	lispanic Origin? (Specify Yes or No-	14. Race - An Black, Wh	nerican Indian,
9	hours after deeth with the Marylan kurel', or iteme 23e or 28e-f ehow al Examinet musi be notified at	Completed by Funeral Director	1 X Never Married 2 ☐ Ma		2 🔯 No	1 ☐ Yes 21 No	Specify:		Specify:	
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2	be filed within all Hygiene. I other then " vent, in Ma	Ö			ege 5+ Te	acher				of Charity
	be fill H d off	Be	17. Father's Name (First, Middle	, Last)			18. Mother's Na	ame (First, Middle, M	laiden Sumame)	
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Maryland	s 1 and 2 should be filed within if Heelth and Mental Hygiene. Item 27 is marked other then other treumatic event, the Mental Control of the Mental Contro		19a. Informant's Name/Relation MOT	^{ship (Type Print)} her Super:	ior 19b. Mail	ing Address (Street	and Number or F	Rural Route Number,	City or Town, State	, Zip Code)
	1 and 2 Heeith em 27 i		<u> Sister Camilla</u>		33			enue, Emmi		
ore	of H		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	State Stormer of Disp	osition (Name of	ce) 3 /1		Oc. Location - City	
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Baltimore	permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		21. Signature of Funeral Service	Licensee				Myers-Durb et, Emmits		
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	Dhaalalaa		Immediate Cause (Final	t only one cause on	each line.	1 -	1 1	1. 10		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to	(r s a consequence s)	scowin	n w	yours	~	Im
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	Sta Registr		31. Date filed (Month, Day, Year MAR 1	pr6.2	Registrar's Signature	books		ے		•

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physician /Medical **Examiner**

Funeral Director 28a-f show notified at

36	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be once.	To Be Completed by Funeral Di	27 Transom Court 11. Marital Status 1 □ Never Married 2□ Married 3 ☑ Widowed 4 □ Divorced	. 13. Was De							
5-00	72 hour "natural dical Ex	eted t	15. Decedent's Ed (Specify only highest grad	Year or Dates: ucation de completed)	16a. Decedent's U (Give kind of life. DO NO						
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and	d be file ental Hy ed othe	Be (17. Father's Name (First, Middle, Last) Halton Anderson								
<u></u>	should nd Me mark	ř	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailing Addr						
∑ S	nd 2 state at trau		Deborah Rogers/Da	aughter	51 Jenk						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Gher (Specify 21. Signature Iney Service Licen	Removal from State 20b. Pla	rce of Disposition (interest, crematory) T. Foard 22. Name						
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in or Vital Records, P.O. Box 68760	IIng Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the bunal-transit	Be Completed by Physician/Medical Examiner	Part II. Other significant conditions of the second	Hospital:	ting in the underlying in the						
o	Phy r this eral di	5 1	27. Manner of Death	28a. Date of Injury	28b. Time of						
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Divisio	To the Hospital or Attend within 24 hours after death. To the Funeral Director; a completely filled in by the f	Medical Certificat	3 Suicide 6 Could not be 4 Homicide determined	t be 290 Place of injury. At home farm etreet fa							
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•	To th withir To th comp	Me	29b. Signature and the of certifier Sachder & MD								
	4		30. Name and address of person who $S \cdot S$ SACHDE	completed cause of death (Item	23a) (Type, Print) North S						
	^	- 4 -	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure						

MAR 2 0 2008

3. Time of Death 6:38 P M 18 2008 March Alice June Noland 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cecil Union Hospital Elkton Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days 1□ M 2XF Yrs Dec. 24, 1931 264-44-7863 76 Georgia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No E1kton Cecil Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21921 14. Race - American Indian, ecedent of Hispanic Origin? (Specify Yes or No-specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. s 2XNo Specify: Specify: White 16b. Kind of Business/Industry Isual Occupation i work done during most of working T use retired) Own Home maker 18. Mother's Name (First, Middle, Maiden Surname) Nina Unknown ress (Street and Number or Rural Route Number, City or Town, State, Zip Code) ins Road, Chesapeake City, MD 21915 Name of or other place) Date 20c. Location - City or Town, State 3-20-08 Funeral Home, P.A. Rising Sun, MD e and Address of Facility Foard Funeral Home P.A. George Street, Chesapeake City, MD 21915 mode of dying, such as cardiac or respiratory arrest, oronary Arkry Disease Unknown unknown 23d. Date of delivery ic pregnancy Month Year (specify) 23e. Did tobacco use contribute to the cause of death? ng cause given in Part I. 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) ctory, office rred at the time, date and place, and due to the cause(s) and manner as stated. ation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

> + Suite 3B, Eleton MD 21921. 22. Registrar's Signature

10023322

3. 19.2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Ам **Physician** 18 2008 March Wallace Winfield Poole /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges

9. Birthplace (State of Country) <u>Southern Maryland Hospital</u> Clinton 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Age (In vrs. last birthday) Sex 1XIM 2□F **Funeral** Months Days Hours Min. 64 578-52-6790 June 9, Maryland Director Usual Residence of Decedent Od. Inside City Limits 10c. City, Town or Location if item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 28a-f show 1XXYes 2 □ No Directo Maryland | Anne Arundel Lothian 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any inury or other traumatte event, the Medical Examiner must be a supplied by inury or other traumatte event, the Medical Examiner must be a 20711 USA 314 Ella Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1) Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2**X**XNo Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Thomas Poole Mary Pauline Willett Poole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Evelyn Poole/ Wife 314 Fila Drive Lothian, Maryland, 20711
Date of Disposition (Name of Date 200. Location - City or Town, State 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gardns 3-22-2008 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home of Funeral Service Linevise 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Partl. Bhter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day been signed by the should be detached Be Completed certificate has b irector, page 2 st Certification: To s after dec. Medical

Hospital or Attending Physician: a 24 hours after des ae Funeral Directo bletely filled in by th within 24 hou To the Fune completely fi

1 ☐ Yes 2 9 ☐ Unknow	□No	4∐Pregnant at time of o	death 5∐Other	(specity)						
Part II. Other sign	ificant conditions of	contributing to death but not res	sulting in the underlying	g cause give	n in Part I.		tobacco us Yes 2□	se contribute to the cause of death? No 3 Probably 4 □Unknown		
						perl	s an opsy formed? 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case refe	rred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☐] No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3	lome 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Dea 1 Matural 2 ☐ Accident	tth 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work 1 ☐ Y	at ? es 2 □ No	28d. Describe	how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	tory, office			(Street and own, State)	d Number or Rural Route Number,		
29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the timi ion, in my op	e, date and place inion, death occu	e, and due to th urred at the time	e cause(s) e, date and	and manner as stated. place, and due to the cause(s)		

15/1/21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCH 18, 2008 LINE CENTER WALDERF, LAD. 20602

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

			1 - For State Registrar	State of Maryland		ent of Health and ate of Death		ene 2008	10670				
		1.28	Decedent's Name (First, Middle, Last,)		0	2. Date of Death		3. Time of Death				
	Physic /Medi		William	Thoma	45	Pugh	0 3 1	Year 2008	7 17:23 AM				
•	Exami	ner	4a. Facility Name (If not institution, give:	street and number) Medical Con	4b, Ci	ty, Town, or Location of Dea	uth	4c. County of Death					
	Funeral Director		5. Social Security Number 6. Sec 233-64-1336 Usual Residence of Decedent	7. Age (In yrs. las	Yrs. If Und Month	der 1 Year If Under 24 Hr ns Days Hours Mir	. (Month, Day,)	(ear) 9. Birth Cou	pplace (State or Foreign intry)				
	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Director	10a. State 10b. County	10c. City,	Town or Location 30-50051 10f.	501-9 Zip Codg	100	g. Citizen of What Co	10d. Inside City Limits 1 Pres 2 □ No untry?				
	1036 ours after death with the Marylar ral", or items 23a or 28a-f show Examiner must be notified at	Funeral	7506 Made 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?		2/849 cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Amer Black, White					
	Maryland 21215-0036 nd 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	eted by	3 ☐ Widowed 4 🗖 Divorced 15. Decedent's Edu (Specify only highest grade	Year or Dates:	16a. Decedent's U	Sual Occupation work done during most of w	orking	Specify: 3/ 6b. Kind of Business/I	2CK ndustry				
	2121 filed within Hygiene. ther than nt, the Me	Completed	Elementary/Secondary (0-12) 17. Father's Name (<i>First, Middle, Last</i>)	College (1-4or 5+)	/ 0	rier	ame (First, Middle, Ma	Shere St	Έρ				
	larylano	To Be	19a. Informant's Name/Belayonship (Ty	Pugh	19h Mailing Addre	ess (Street and Number or H	ia H	tale	(in Code)				
1	tem Hear		20a. Method of Disposition 1 Burial 2 Ocernation 3 R 4 Donation 5 Other (Specify)	(5:5 fer) 20b. Pla	205 / ce of Disposition (A	Name of or other place)	Upper 1	11 11	M7 20772				
:	Baltimol permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service License	ee Ka	newtory of 22. Nime Bemi	and Address of Facility The Smith F. H.	917 W. Salish	Eschella Lochella 144 Mary	swore Street land 21801				
	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. the cause on each line.		node of dying, such as cardi		t, f	Approximate Interval Between Onset and Death				
	econted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CLOSTROWW DIFFICUE QUIS Due to (or as a consequence of):										
336	BOX 68/60, eath certificate be executed attending physician and for use as the burial-transit	dical											
1-49.	atter for u	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	pregnancy (specify)		23d. Date of delivery Month Day Y						
	COLGS, P.O. w requires that the de been signed by the s should be detached	d by Pr	Part II. Other significant conditions cor	ntributing to death but not resulti	ng in the underlying	g cause given in Part I.		cco use contribute to					
2	N 60 81 CI						24a. Was an autopsy performe 1 Yes 2	prior to c	topsy findings available ompletion of cause of				
	Or VITal Physician: T this certificat al director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: Inpatient 2 EF		Othor	eath (Check only one)	. Flow (2)					
	Attending Phy r death. setor: After this by the funeral di	ition: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Injury at Work? 1 Yes 2 No		flome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
William	LIVISION tal or Attending s after death. al Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, fact	ory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,				
4	DIVISION OF VITAL HA To the Hospital or Attending Physician: The I within 24 burus after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical ((Check only 2 Medical Examinate one)	sician: To the best of my knowle ner: On the basis of examinatio and manner stated.	n and/or investigati	on, in my opinion, death oc	ce, and due to the cau curred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)				
•	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier			P63433	290	3 19 08	, Day, Year)				
	3 1		30. Name and address of person who co	106 MW 2010.	ST, #50	4B, MD2	1804						
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0 200	32. Fegistrar's Signatur	A Acres								

08-02200 Sharon Robinson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

2008 10671

aron Robinson	1-	State of Maryland / Department of Certificate of		Reg	No.	
Physician	R	egistrar . Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Physician Examin	er	Sharon V. Robinson		Month March 19, 2	4c. County of Dea	1132 hrs
	4	a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	Ab. City, Town, or Location of De Annapolis		Anne Arunde	
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24		(MM/DD/YYYY) 9. B Fore	irthplace (State or ign
Director		216-70-4190 1 M 2 XF 51 Yrs		Feb 2	6 1957 ^c	ouMaryland_
any	_	Jsual Residence of Decedent 0a. State 10b. County 10c. City, Town or Locati	ion			10d. Inside City Limits
≹ .⊤	_ M	aryland Anne Arundel Annapol	is			1 X Yes 2 No
faryland 28a-f show I at once.	Director	0e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
tith the Maryland 23a or 28a-f sho		1655 Colbert Rd.	21409		USA	erican Indian, Black,
	- I	1 Never Married 2 Married Armed Forces? If Y	as Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	White, etc.	
Per death w		1 Yes 2 X No 3 Widowed 4 XDivorced If Yes, Give Year	Yes 2 X No specify:			lack
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	핡	during m	nt's Usual Occupation (Give kind nost of working life. DO NOT us	d of work done e retired)	16b. Kind of Busines Sandy P	
6 172 ho an "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	1 Attendant	•	State P	
21215-0036 July be filed within 7 Mental Hygiene, marked other than ic event, the Medica	틹	17. Father's Name (First, Middle, Last)		Name (First, Middle, M		
	Be C	Woodrow Pohincon	Lola	Cromwell		
2121: ould be fil I Mental F marked ic event,	ᆰ	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number	er or Rural Route Num	ber, City or Town, St	
MD d 2 sho lth and n 27 is		Dadila luck(Daughter)	Bruton Ct.	Apt K G16 Date	20c. Location - City	e, Ma. or Town, State
imore, MD 2121 Pages 1 and 2 should be finent of Health and Mental anti If item 27 is marked or other traumatic event,		Permayal from State crematory or o	ther place)	3-27-08	Baltimo	ro Md
Page ment of	Į	1 Denotion 5 Other Specify:	rematory	ong Mort		
Baltimore, permit. Pages 1 and Department of Heal Important; If iten injury or other tra		1. M Ann Mon 483 8:	21 West St.	Annapolis	s, Md. 2	A. 1401
Physician	\dashv	28a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as care	diac or respiratory arre	est, shock, or heart	Approximate Interva Between Onset and
ledical		failure. Ust only one cause on each line. Immediate Cause (Final disease a. Emphysematous Anthracotic	Lungs of Crack Co	caine Use		Death
_aminer		or condition resulting in death) Due to (or as a consequence of):				1
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated C. Due to (or as a consequence of):				
nted d ansit	E	events resulting in death) Last d.				
50, te be executed ysician and burial - transit	ledical	X UNPENDED AMENDED 23a,Pt.II,27 per	ME g878 4/10/08 an	nh		
760, cate be physici	Me	IF FEMALE: 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the	Fetal death 3 Ectopic	pregnancy	23d. Date of del	ivery Day Year
Box 6876(e death certificate the attending phy led for use as the b	sician/N	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
Box death	Physi	1 Yes 2 No 9 V Unknown 9 Unknown	- in Dom	23e Did t	obacco use contribut	e to the cause of death?
, P.O. Be ires that the de signed by the	y P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Par			Probably 4 🗹 Unknown
S, P	ted t	Hypertensive Heart Disease; Probable Sepsis		24a. Was	an 24b. Wer	e autopsy findings availab
tal Records rian: The law requi certificate has been	Completed by				ormed? dea	r to completion of cause of th? Yes 2 No
Rec The ficate	Con	Country and the second	26.Place of Death (2 No 1	700
ital sician; is certi irector	Be	25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatie	Other	Nursing Home 5	Residence 6	Other:
Division of Vital Records, red or Attending Physician: The law requirers after cleath. a) Director: After this certificate has been silled in by the funeral director, page 2 should the complexity of the control of t	n: To	1 ✓ Yes 2 No 27. Manner of Death 28. Date of Injury (Month, Day, Year) 28b. Time of Month, Day, Year)	of Injury 28c. Injury at Work	1	how injury occurred	
ion ttendi leath. stor: /	atio	1 Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, st			(Street and Number	or Rural Route Number, Ci
Divis al or A safter of in by	Certification:	Suicide Could not be determined (Specify)	reet, factory, office building, ou	or Town,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	al Ce	4 Homicide	curred at the time, date and pla	ce, and due to the car	use(s) and manner as	s stated.
To the within 2 complete	Medical	one) 2 Medical Examiner:On the basis of examination and/or investi and manner stated.	gation, in my opinion, death occ	Julieu at the time, dat	29d. Date signed	(Month, Day, Year)
F > F 0	Ž	29b. Signature and title of certifier	O.C.M.E.		March 20, 2008	
		CALLA Company of death (Ham 22a)				
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penr	n Street, Baltimore, MD	21201		
	tato	31. Date filed (Month, Day, Year) 32. egistrar's Signature	1 4.			

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death SULLIVAN Month O3 2008 **Physician** ARIE VELYN 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 80 577-36-7074 Vrs Director 9/23/1927 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Marvland Anne Arundel Annapolis 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 973 Lanna Way 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Yes 2 1 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Hall, Sr. Irene D. Joliffe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Sullivan/ Son 973 Lanna Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 3/18/08 Edgewater, MD 21. Sign of Funeral Se 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a quence of): 104 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

certificate be executed Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physiclan: within 24 hours after death. show

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be r

72 hours after

permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumair.

Physician /Medical

Examiner

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page 2

certificate

this

After t

physician

attending

the

signed by

Baltimore, Maryland 21215-0036

Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Alatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

rho condeted cause of death (Item 23a) (Type, Print) Name and address of erson

29c. License number 29d. Date signed (Month, Day, Year)

ILHAEL

HIGHWAY ANNAPOLIS MOZIYOI

State Registrar y, Year) 1 8 2008 32 Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March **Physician** 2008^{ear} 18, Carrie Stacey A00:8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 2,1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Ohio **Funeral** Months 579-03-8063 92 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√ No Director MD Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2880 Smith Point Road 20662 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Shuttleworth Hannah Keeler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stacey/Son 2880 Smith Point Road, Nanjemoy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Brinsfield-Echols Crem. 3/20/08 Charlotte Hall,MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee M00945 ²²AREHARI ECHOL'S FUNERAL HOME, P.A aL 211 St. Mary's Ave. La Plata,MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perforn 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No P this funeral 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director: After t 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760,

State

completely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

39 Name and brokess of person who completed cause of death (Item 23a) (Type, Print)
Pr. WISDIS(U) M.D. 12070 OD LINE GUYA WAVILE, Und. 2060 Z

32. Raistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:17 AM 19. March 2008 Ronald Schomo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F Sept. 18, 1934 Pennsylvania Director 184-26-2094 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Maryland Cecil Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number States 21921 United 147 Woods Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No Army If Yes, Give Year or Dates 1957-59 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processing State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Siwik Charles Schomo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 147 Woods Way, Elkton, Maryland Margaret Schomo / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: if it any injury or o 21. Signature of Experal Service Lice 25, 2008 Newark, Delaware Mayerdale Crematory 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one complications are according. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) freumonia Unknown **Physician** /Medical Due to (or as a consequence of): Examiner BLER Sequentially list conditions, if any, head of the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner y physician and Due to (or as a consequence of): Physician/Medical attending properties for use as use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð hymphoma 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 2 No 1 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: 1 ☐ Yes 2 ☑ No 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ie Hospital or Attendii 24 hours after death. Ie Funeral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

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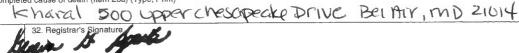
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State Registrar

Medical

31. Date filed (Month, Day, Year) 2008 MAR 2 0

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zubair

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

063420

29d. Date signed (Month, Day, Year)

March 19, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month **Physician** 550 Um 1610 M Upersac may 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Pock vill 11017 Ear 5 Gate If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Days Hours Director 79 28, 1928 Trinidad Nov. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show be notified at 1 ▼ Yes 2 No Director MD Rockville Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with ò d other than "natural", or items 23a event, the Medical Examiner must b 11017 Earlsgate Lane 20853 Trinidad Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ₩ No West Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any Injury or other traumatic event, <u>th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Ramgattie Singh Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra McShine - Daughter 11017 Earlsgate Lane Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 【Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematorium 3/19/2008 Falls Church, Virginia 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licensee. 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCVL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulcase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and Due to (or as a consequence of): burial P.O. Box 68760. attending physician for use as the buria Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 1 ☐ Yes 3 No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown the þ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page ; perform certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ۵ this within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintenance and place are the cause(s). Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Check only 29c. License number ature and title of certife 29b. 29d. Date signed (Month, Day, Year) 1200418 2101 medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER

Registrar

State

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** STEINMAN 3/17/2008 11:55P ELEANOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY POTOMAC MANOR CARE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🔀 F 88 NEW YORK, NY Director 10/14/1919 <u>056-01-8847</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No POTOMAC Director MONTGOMERY MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20854 USA 10714 POTOMAC TENNIS LANE Funera 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If Item 27 is marked other tha any injury or other traumatic event, the A once. the LAW SECRETARY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSE HERMAN MORRIS KOLKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 857 WEST DRIVEWAY STREET, GLEN ELLYN, IL 60137 BARRY ERLICH- NEPHEW Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 □ Cremation 3 Removal from State 03/19/2008 ELMONT, NEW YORK BETH DAVID CEMETERY 4 Donation 5 Dother (Specify) of Futer Survice Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 21. Signatura INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Demento /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending plant for use as 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Knknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed' certificate 2 No 2 700 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 [Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8/08 P0054566 11 9801 Georgia Avince # 1-17 30. Name and address of rson who completed cause of death (Item 23a) (Type, Print) Suridha Bhog avill 31. Date filed (Month, Day, Year) State MAR 1 9 2008 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box 68760

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Records,

Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** March 16, Edward P. Srsic, Sr. 2008 9:27 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 159-22-5930 13, 1925 Director Oct. Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes **2**XNo Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with 1 and Mental Hygiene. Is marked other than "natural", or items 23a or 2 299 Hurley Avenue 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Tyes 2 No. Specify Completed by 3 Widowed 4 □ Divorced WWII Year or Dates: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Residential & Commercial Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Property Manager traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be facent of Health and Mental I Peter Srsic Martha Majewska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s f Health Kathleen M. Srsic-Stoehr/Daughter 8758 Brook Road, McLean, Virginia 22102 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. March 24 P Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Memarce urke 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Con /Medical Due to (or as a consequence of): Examiner Mary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as attending properties as IF FEMALE: use yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No detached Records, P.O. 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? 1 ☐ Yes 2 X No certificate or Vital 1 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 2 1 Inpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Division Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ∏ Yes 2 ∏ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month Day, Year) 2

State Registrar 31. Date filed (Month, Day, Year) 19 MAR

30. Name and address of person who completed cause

2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 16 Day 2008 Year **Physician** 1545 M Malcolm Ira Spiritos /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville 6111 Montrose Road Apt 525 Montgomery 9. Birthplace (State or Foreign County ew York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. 10971571958 Months Hours 1⊠M 2∐F 49 Yrs Director 118-54-4487 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event the Marketon. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1XIYes 2 No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20852 6111 Montrose Road Apt. 525 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify. Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Services Law Firm 6 months 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doris Reiss Maurice Spiritos ٤ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 International Dr. #553 Silver Spring, MD 20906 Doris Spiritos - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland Judean Mem. Gdns. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, Md 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Caset and Death Immediate Cause (Final Physician pder 4/4 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** OWns Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ۲ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? Certification: Natural 5 Pending investigation 1 Tyes 2 No 2 Accident neral Director: , filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. Gignature and title of certific 29c. License number w mo O mE PNIK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210/ my BRECKER mo DME 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

19

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Registrar

State

Kshama Garg, MD

MAR

2008

19

31. Date filed (Month, Day, Year)

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	• • •		For State Registrar	State of Ma	•	epartment of F Certificate of			ene g. Mo. 008	10580		
	Physici	en.	1. Decedent's Name (First, Middle, Last)	_	_			2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al		Raymond	Soo	41. Cit. T	a Landina of Danie		7, 2008	4:20 A M		
	Examin	er	4a. Facility Name (If not institution, give stitution) Homewood	reet and number)			r Location of Death		4c. County of Death	~ t ~ ~ ~		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	day) If Under 1 Year	iamsport If Under 24 Hrs.	8. Date of Birth	Washing 9. Birthp	lace (State or Foreign otry)		
	Director		578-12-3024 1X	M 2□F	86 Yr	s. Months Days	Hours Min.	Jan. 8,	1921 Washi	ington DC		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location			1	0d. Inside City Limits		
	Maryla f shored	or	Maryland Montgom	eru		Rockvi	110			1 ⊋Yes 2 □ No		
	r 28a-	Director	10e. Street and Number	9		10f. Zip Code		10	g. Citizen of What Coun	itry?		
	th with	al D	5806 Ridgway Ave	•		208	351		U.S.A.			
	er dea tems	Funeral	T T T T T T T T T T T T T T T T T T T	2. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc.			
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	1944	1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	Specify: White		
9	2 hou latura ical E	ted	15. Decedent's Educa	ition	16a. D	ecedent's Usual Occup	pation	1	16b. Kind of Business/Industry			
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)	Give kind of work done ife. DO NOT use retire		king	_			
7	lled w dygier ther th	Co	17. Father's Name (First, Middle, Last)	4		Sales Rep.		e /First Middle M	Rentals Middle, Maiden Surname)			
and	d be f ental f ced of	o Be	Bernard C. Soo					; E. Cole				
Ž	shoul nd Me mark	To	19a. Informant's Name/Relationship (Type	City or Town, State, Zip	Code)							
ž	and 2 alth a 27 is		R. Michael Soo (S	e, Maryland 20850								
ore,	of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		Date 29,	Oc. Location - City or To	wn, State					
Ē	. Рад tment tant: I jury o		4 □ Donation 5 □ Other (Specify)	Smithsburg,	Maryland							
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21, Signature of Funeral Service Licensee			22. Name and Addre			is Funeral urg, Maryla			
68760, ch	Physician physician and physician and physician and sthe prinal-transit	sal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of twig, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, cause to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of delive Month	ery Day Year						
Records, P.	res tha igned l		Part II. Other significant conditions control	ibuting to death bu	t not resulting in th	ne underlying cause giv	ven/in Part I.		acco use contribute to th			
S	requi	eted	Trus ER	we a	- Jac	VOICE ON IT!	1/1/2016	1 Yes		ably 4 □Unknown		
	Attending Physician: The law ar death. rector: After this certificate has to by the funeral director, page 2 s	Completed by	ITINION PORM	CCVITIC				24a. Was an autopsy perform 1∐ Yes 2	prior to cor	psy findings available mpletion of cause of 2 No		
Vita	siciar certif rectol	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	spital:		otiont 3DD04 Ott		th (Check only one				
ō	g Phy er this	2 1	1 Yes 2 No	1 ☐ Inpatier 28a. Date of Injur	y 28b. Tin	ne of 28c. Inju	4 Nursing H	ome 5 L Resider 28d. Describe hov	nce 6 Other (Specif) w injury occurred	<u>v) </u>		
0	ath. ir: Affe	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		rk? Yes 2 □ No					
Division or	al or Atte s after de: al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At home, farm . (Specify)	, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	clan: To the best on er: On the basis of and manner sta	examination and/	death occurred at the ti or investigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) end manner as state and place, and due to	tated. the cause(s)		
	To th within To th comp	Me	29b. Signature and other of certifier	_	χ	29c. Licens	se number	29	d. Date signed (Month,	Day, Year)		
}			M ANSW	ESICOR !	MACTO		(706)		3/27/20	C.f		
	1.		30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Ty	(P) A	Horas	ATTERIZAT	11/31	7()		
	∖0 Sta	te	31. Date filed (Month, Day, Year)	32. Registra	s Signature	YINIPE	11/100	14 June 0	MO 11	7		
	Registr		APK U 2 200	10 Sugar	an the	Dogale 5						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** TRUAX JR 1200 M 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Severna Park 761 Trenton Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2□F 114-22-1673 78 Yrs New York Director Jul. 14.1929 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Severna Park 1 ☐ Yes 2 X No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21146 761 Trenton Avenue Funeral death v 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 XYes 2 ☐ If Yes, Give Year or Dates: ^{2□No} 1948-1 ☐ Never Married 2 → Married White Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: þ 3 Widowed 4 Divorced 1955 event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) is marked other than United Airlines Administrative Manager 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Virginia Dempsey es 1 and 2 should b of Health and Menta item 27 is marked Walter Truax ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 761 Trenton Avenue Severna Park, MD 21146 Abbie R. Truax/ Wife Baltimore, permit. Pages 1 a Department of Hee Important: If Item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Mar. 18, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory 2008 Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Juneral Service Licensee 23a. 6/11. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only be cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final lisease or Indition PULMON ARY 1010PATHIC FIBROSIS 104 **Physician** isease or ndition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical law requires that the death certificate 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) MAR 1 8 2008

Name and address of person who

1 CHAER

2. Figistrar's Signature

se of death (Item 23a) (Type, Print)

EFENSE HIGHWAY ANNAPOLIS MD 21401

O8-02344 Egypt Thomas Physicia Medical Exami Funeral Director		1- For Sta Registrar 1. Decede 4a. Facili Sou 5. Social Unk Usual Re
21215-0036 ald be filed within 72 hours after death with the Maryland Martal Hygiene, marked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	o Be Completed by Funeral Director	Md 10e. Stree 6 9 9 11. Marita 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death nt's Name (First, Middle,Last) Month Day March 24, 2008 1630 hrs y Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's hern Maryland Hospital Clinton 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. Foreign Months Davs Hours Min 20b3 Country) 1X M 2 F Yrs 28 Δ Julv idence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Capitol Heights 10f. Zip Code 10g, Citizen of What Country? 54 Walker Mill Road 20743 United States 14. Race - American Indian, Black, Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No If Yes, Give Year dowed 4 Divorced Yes 2 X No specify: Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry edent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) tary/Secondary (0-12) College (1-4 or 5+) None None 's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Thomas Neesie erette Inghurm mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 2's permit. Pages I and 2 should Department of Health and Me Important: If item 27 is mainjury or other traumatic es Walker Mill Road 6954 Neesie Thomas/mother 20b. Place of Disposition (Name of cemete 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3/28/08 Donation 5 Other Specify: Harmony Mem. Park Landover, 22. Name and Address of Facility 21/Signature of Funeral Service Licensee Hodges & Edwards F.H. 3910 Silver Hill Rd. Suitland .Md. Part I. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart liter. List only one cause on each line. Approximate Interva Physician Between Onset and /Medical Death a. Drowning xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical 23a,27,28a-f per ME g878 4/23/08 amh X UNPENDED signed by the attending physician be detached for use as the burial Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 ✓ No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other4 After this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes ۵ No uneral 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b, Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No neral Director: , Pending Fnd 3:40p 3/24/08 Subject drowned 2 Accident Investigation 28f. ocation (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide orTown, State) 54 Walker Mill Rd.#A.Capitol Hgts.D determined (Specify) Found in tub 4 X Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 25, 2008

Hospital or Attending Physician: 24 hours after death. Division of Vital within 24 hours a

To the Funeral I

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State 32 Segistrar's Signature. Registra APR 0 2 DHMH 17 Rev 1/2001 ORIGINAL

completely cal 29a. Certifier 1

29b. Signature and title of certifier

and manner stated

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM#24a, 26, perVERB, C878, 4/2/08, WS
State of Maryland, Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 27. 2008 HARRY Α TYERYAR March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 X M 2 □ F Yrs. 8-14-1942 MD Director 213-40-7021 65 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🔀 No Directo Frederick Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21702 160 Willowdale Drive by Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White iit. Pages 1 and 2 should be filed within 72 rows artment of Health and Mental Hygiene. 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sole Proprietor Escavation/ Septic 1 Ó 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lijury or other traumatic evone. Katherine Irene Boone Charles A. Tyeryar ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 160 Willowdale Dr. Frederick MD 21702 Patricia Long Fiancee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/31/2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee Frederick MD 21701 M01176 106 East Church St, Part 1. Fover the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes aldiac Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year for 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tate has been signe page 2 should be o Interchion Myocardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Stroke No No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural al Director Affr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral Completely filled 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58756 3,27,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

be

State

31. Date filed (Month)

186

32 Registrar's Signature

Thomas Johnson Dr #105 md 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 14,2008 3:55 March John E. Virnstein, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 1392 Stratton Dr. 8. Date of Birth Dec 12,1936 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Washington DC Months Hours 1 X M 2 □ F 71 Director 577-50-1997 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No MD Montgomery Rockville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20854 1392 Stratton Drive Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmel Botazzi ည John E. Virnstein, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4331 Town Common Circle, Atlanta, GA 30319 Jill Termini/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Falls Church, VA National Crematory | 4-18-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc 21. Signatura of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): **Examiner** Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death asn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 x No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: Hospital: 1 XYes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient Certification: To After this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

egistrar's Signature

30. Name and address of person who completed cause of death frem 23a) (Type, Print)

2008

32.

Neill Kennedy,

19

31. Date filed (Month, Day, Year)

MAR

M.D. 530 Wisconsin Ave, Chevy Chase.MD

D0013187

March 17,2008

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4		Registrar Decedent's Name (First, Mid	ldle, Last)			- Illica	e or i	Jean	,	2. Date of D	Reg. No leath), <u>/</u>	1119	3. Time of Death	
ysici			Miriam G.	Wood						Month March	Da 16		Year 2008	3:15 a ^M	
Medic camin	- 10	4a. Facility Name (If not institut				4b. City	Town, or	Location	of Death	TATE			y of Death		
		Sunrise As	sisted Living	.			Si1	ver Sp	pring			Мо	ntgome	ry	
neral		5. Social Security Number	6. Sex 1 M 2 F	7. Age (In yrs.		Months	r 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of E (Month, L	irth Day, Year,)	9. Birthp	place (State or Foreign	
ctor		220-32-5382 Usual Residence of Decedent	10.11.25	89	Yrs.					Novembe	r 10,	1918	Geo	orgia	
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e not	Director	10e. Street and Number				10f. Zi	p Code				10g. Ci	tizen of	What Cou	ntry?	
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m m	Funeral	11. Marital Status	Armed Fo		.S. 1	Was Dece If Yes, spe	edent of H	ispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or h Rican, etc.)	10-		ce - Americ		
amir	by F	1 ☐ Never Married 2 🗷 M 3 ☐ Widowed 4 ☐ Dîvord	If Yes. Gi	ive		1 🗆 Yes	2 X No	Specify	/ :			Speci		TH	
al E	ed t		ent's Education	atos.	16a. De	cedent's Usi	ial Occup	ation			16b. k	(ind of E	Business/In	White	
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any injury or other traumatic event, the Medical Examiner must be notified at once.	٦ ا		n Brown							anche W					
traum		19a. Informant's Name/Relation				•				rai Route Nun				o Code)	
ther		Janet Stoehr 20a. Method of Disposition	- Daughter	20b. F		9 Zeigl sposition (Na		y, Si		pring, l			0904 - City or T	own State	
0 10 /		1 Burial 2 □ Cremation		State	cemetery, c	rematory or	other plac	i i			l				
Inlun		4 Donation 5 Other 21. Signature of Funer Servi) /	Ge	orge W	ashingt 22. Name a		-		20/2008	Ad	етрп	i, Mar	yland	
any		Tomas	Heen	Lou.	ļ	Hines-F	inald	i Fune	eral H	lome, Inc		erin	o Mar	yland 20904	
91		23a Part1. Enter the disease	or complications that	caused the deat	th. Do not			_				prin	g, 11d1	Approximate Interval Between	
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dical		resulting in death) Due to (or as a consequence of):													
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use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna								23d. D	ate of deliv	verv	
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be detached for use	by P	Part II. Other significant cond	litions contributing to o	death but not res	sulting in the	e underlying	cause giv	en in Part	t I.	23e. Die	d tobacco	use cor	ntribute to	the cause of death?	
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funeral director, page	7	1 Yes 2 No				tient 3 D		4 🗆 1	Nursing Ho	ome 5 Re				Assisted Living	
funer	ion:	27. Manner of Death 1 ■ Natural 5 □ Pen	unig	nth, Day Year)	28b. Tim Inju		28c. Injur Wor	yat k? Yes 2[28d. Describ	e how inju	ury occi	ırred		
by the	Certification:	3 Suicide 6 Cou	stigation Id not be 28e. Plac	e of injury - At h	ome, farm.			162 2	7140	28f Location	(Street a	nd Num	aher or Rui	al Route Number,	
d ii	ertif	4 ☐ Homicide dete	ermined build	ding, etc. (Speci	fy)		.,,				own, Sta		1001 01 1101	arriodic Nambor,	
/ filled		29a. Certifier 1 🛣 Certif	ylng Physician: To th	e best of my kno	owledge, d	eath occurre	d at the ti	me, date a	and place,	, and due to ti	ne cause(s) and r	nanner as	stated.	
completely filled in	29a. Certifier (Check only one) 29b Signature and title of certifier 29c. License number										ie, date ai	nd place	e, and due	to the cause(s)	
Com	Š	29b. Signature and title of cert	ifier	-5-X	12.	. 25	c. Licens	e number	r		29d. D	Date signed (Month, Day, Year)			
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		30. Name and address of nor	on who completed cau	ise of death (Iter	m 23a) (Ty	oe, Print)									
		Sean Shahriar				pshire A	Avenue	, Sui	te #30	05, Silv	er Spi	ring,	MD 20	904	
Sta egistı		31. Date filed (Month, Day, Ye MAR 1	9 2002	Registrar's Sign	ature	1. 15									
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State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March 16, Day 2008^{ear} **Physician** 6:00P. M Wagner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctors Community Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (Star County) New York 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑** M 2□ F 89 112-05-6496 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 0c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's Bowie 1 Yes 2 No Funeral Director 10f. Zip Code 20715 10g. Citizen of What Country? United States 10e. Street and Number 2605 Kingsley Lane 12. Was Decedent Ever in U.S.

Agned Forces?

14 Yes 2 □ No

If Yes, Give
Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Wagner Esther Litvack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Kingsley Lane Bowie, Maryland 20715 19a. Informant's Name/Relationship (Type. Print) Robert Wagner -son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 3/21/2008 20a. Method of Disposition 20c. Location - City or Town, State ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature-of Funeral Service License Bohala V. Bbrgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician and defacted for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by I Hypertension; Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 1∐ Yes the Hospital or Attending Physician: nin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 [XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) D60120 March 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4000 Mitchellivlle Road, #B216 Bowie, Maryland 20716 Ahmd W. Hagothmn, 31. Date filed (Month, Day, Year) gistrar's Signature State MAR 19 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 2008 EVELYN WHEAT 12:02pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Chester River Hospital Chestertown Kent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Yrs. 78 8 1930 Michigan Mar Director 378-28-2670 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City. Town or Location in than "natural", or Itema 23a or 28a-f show the Medical Expringer must be notified at 1 Yes 2 □ No Directo MD Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 417 Wood Lane 21629 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Customer Service Agent Motor Vehicle Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any ligury or other traumatic event 2008. Arthur Trolley Mary Martha Essen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara George (daughter) 417 Wood Lane Denton, MD. 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ' 4 □Donation 5 □ Other (Specify) Kent Cremation 3/29/08 Smyrna, DE. Calena Funeral Home of Step 118 West Cross St. Galena, 21. Signature of Funeral Service Licensee Stephen ena, MD. L. Schaech 21635 M00510 Approximate Interval Between Onset and Death 23a. Part1. Enter the cisease, or complications that caused the death, shock, or heart ailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause IF inal disease or condition resulting in death) Physician 29200 /Medical Due to (or 4s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of). Examine The law requires that the death certificate be executed physician and s the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes BUNO ٩ this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 垢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 08 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Benjamin M.D. 6602 Church Hill Rd. Chestertown, MD. 21620 31. Date filed Month, Gay 2 eas 008 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Whittacre 25, 2008 18:20 G. MARCH Eleanor /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) Aug 28, 1929 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours Days 1 ☐ M 2 ☐ F 78 Director 196-28-8269 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☐ No Allegany Cumberland MD 28a-f sh notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or r must be n 21502 USA 15007 Laurel Ridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Hygiene. other than "natural", or Items ? ent, the Medical Examiner mu 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 💑 Maryland 21215-0036 Specify. Specify: þ white 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) own home homemaker ages 1 and 2 should be filed wi ent of Health and Mental Hygien It: If item 27 is marked other th y or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Peduto Castelli Vincent Castelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21502 15007 Laurel Ridge Road Cumberland Eric Whittacre son Saltimore, Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or 3/31/2008 PA Holy Souls Catholic Cemetery Pittsburgh 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Fundral Service Lioenture 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebral vascular accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 212 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 1 2 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? After t (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No М To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 W. THIRD ST. MBERLAND, MD 21502 m.D SNOW. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 02

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month March 16, 2008 Helen Xides Zuppas 11:25 p^M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6704 Sulky Lane North Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M 2 ₹ F 416-40-5220 80 Dec. Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 Sulky Lane 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Program Administrative Officer NIH/NCI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Xides Chariklia Giannoulis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen S. Zuppas/Son 6704 Sulky Lane, North Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 20c. Location - City or Town, State 20 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd,. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee mediane Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 18 Months Glioblastoma Multiforme Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death 1☐Live birth Month Dav Year 4☐Pregnant at time of death 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

the death certificate be executed

Box 68760

P.O. 1

Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f shov dical Examiner must be notifled at

arment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natul Injury or other traumatic event, the Medical

Department o Important: If any Injury or

Pages 1 and 2 should be innent of Health and Mental

death

filed within 72 hours after

3altimore, Maryland 21215-0036

Director

ρ

Completed

as 1

Examine physician and s the burial-trans Physician/Medical attending p for use as signed by the a 2 After this certificate has been si funeral director, page 2 should I Completed Be ဥ

Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 2☑No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year) D62234

March 18, 2008

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Manish Agrawal, MD

9707 Medical Center Drive, #300, ROCKVILLE, MD 20850

Registrar

Medical

19 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State-Amend 20b-c, per FH g878 4/3/08 amh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:00p^M 26 2008 ROBERT XAVIER BROOKS, JR MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MD 3523 MILLVALE ROAD RANDALLSTOWN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Months Davs Hours Director 35 BALTIMORE 216-84-3368 6/23/1972 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show at 1 X Yes 2 No iral", or Items 23a or 28a-f si Examiner must be notified Director MD BALTIMORE RANDALLSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 3523 MILLVALE 21244 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK ģ 3 Widowed 4 Divorced 'natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "I ury or other traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) SECURITY AGENCY SELF-EMPLOYED 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT XAVIER BROOKS, SR MICHELLE ASHE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3523 MILLVALE RD, BALTIMORE, MD 21244 MICHELE BROOKS - WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of II Important: If Ite any injury or ot Mount Zion Cemetery or other place) 1 □ Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) ARBUTUS CEMÉTERY 4/2/2008 21 Signature of Funeral Service Licenses 22. Name and Address of Facility 4600 LIBERTY HEIGHTS BALTIMORE, MD 21207 Ho HOWELL FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE LUNG DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine SLEEP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed MARBID and -tra that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burialby Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed ESOPHAGEAL REFLUX 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification:

P.O. Box 68760. Division or Vital Records,

1 Natural 2 ☐ Accident 5 ☐ Pending investigation

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of pertifier

29c. License number D27157

APRIL, 15 2008

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

RAYNOLD DEPESTRE 3100 LORD BALTIMORE DR. #110 BALTIMORE MO 21244 31. Date filed (Month, Day, Year) APR 0 3 2008 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Within 24 hours after www. To the Funeral Director: Af

eonard Baublis		State of Maryland / Department of Health and Menta For State Certificate of Death		eg. No. 200	8 10691
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ith	3. Time of Death
ledical Exami		Leonard V. Baublis	Month March 27		0325 hrs
- 1 mg		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of St. Agnes Hospital Baltimore	Death	4c. County of Deat	h
>		St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1	24Hrs 8 Date of Bi	rth(MM/DD/YYYY) 9. Bi	rthplace (State or
Funeral Director		215-28-3058	Min. 04-05-	Forei	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd show	_	MD Harford Forest Hill			1 Yes 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
death with the Maryland or items 23a or 28a-f sho or items 23a or 28a-f sho must be notified at once.		1603 Barbara Ct 21050		U.S.A.	
eath with items 2 ist be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married Forces? 13. Was Decedent of Hispanic Original Information of the Info		0- 14. Race - Ame White, etc.	rican Indian, Black,
er dea , or it r mus		3 Widowed 4 Divorced If Yes Give Year 1 Yes 2 No specify:		Specify: W	hite
urs aft tural" amine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give ki		16b. Kind of Business	/industry
5 72 ho m "na sai Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT u	use retired)		
003(within iene. er tha	dmo	12 2 Accounting		Exxon	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	Be Co	The date of the da	s Name (First, Middle, a Silanska		
212 uld be Menta mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb			te, Zip Code)
imore, MD 2121. Pages I and 2 should be fit ment of Health and Mental I tant: If item 27 is marked or other traumatic event,	Γį	Dolores Baublis (Wife) 1603 Barbara Ct F	orest Hill	L, MD 21050	
Fe, F Healt Fitem	ı	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
Pages nent ol		4 Donation 5 Other Specify: HIghview Mem. Gar.	03-31-2008	Fallston	, MD
Baltimore, MD 21216 permit. Pages I and 2 should be fil. Department of Health and Mental H Important: If item 27 is marked. injury or other traumatic event, t.	ı	21 Signature of Funeral Service Licensee 22. Name and Address of Facility	Schimunek	Funeral Ho	me of BelAir
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca			21014 Approximate Interval
Physician /Medical		fallure. List only one cause on each line.	and an experience of an		Between Onset and Death
* ↑ ° ⊂xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
() ř		Sequentially list conditions, b			
	ije	If any, leading to immediate cause. Enter Underlying Cause			
ansit. mg . mg	Physician/Medical Examiner	(Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
i, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and the detached for use as the burial - transit	dica	UNPENDED AMENDED			
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the buri	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live high		23d. Date of delive	
certife on certife use as	cian	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic past 12 months? 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month	Day Year
BO) e deatl the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	vg		
that the detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco use contribute es 2 No 3 Pr	
rds, Frequires	fed	Hypertensive Atherosclerotic Cardiovascular Disease	24a. Wa		autopsy findings available
Records The law requi	Completed		auto		completion of cause of
tal Rection: The certificate ector, page	Con	00 Phys. (D. 11)		2 No 1	Yes 2 No
ion of Vital Records, trending Physician: The law requirienth. tor: After this certificate has been si the funeral director, page 2 should b	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 1 DOA Other 2 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA Other 3 DOA OTHER 3 DOA	Nursing Home 5	Residence 6 Ott	ner:
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Hospital 24 hours at Funeral etely filled	Çer	4 Homicide determined (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	I - 695 & Wi	lkens Ave., Catonsvil	
Division of Vital I vital Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla one)	ice, and due to the ca curred at the time, dat	use(s) and manner as si e and place, and due to	ated. the cause(s)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
		() on mb O.C.M.E.		March 27, 200	3
		30. Name and address of person who completed cause of death (Item 23a)			
5		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201		
Si Regis	tate trar	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature			
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			For State Registrar	State of M	Maryland / Depa	artment of rtificate o			Rag. N	CHH D	1069	92
	Physicia	an	1. Decedent's Name (First, Middle, L					2. Date Mont	of Death -2008	ay Year	3. Time of 0	Death M
	/Medic Examin		<u>Lucille J. Burc</u> 4a. Facility Name (If not institution, g Franklin Woods		or)	4b. City, Town	n, or Location o	f Death	4	c. County of Death		
	Funeral		5. Social Security Number 6.		Age (In yrs. last birthday)	If Under 1 Ye Months Day	ar If Under 2	24 Hrs. 8. Date Min. (Mont	of Birth	9. Birth	nplace (State or	
	Director		225-03-1937 Usual Residence of Decedent	1□M 2 ∏ F	96 Yrs.	Motitus Day	ys Hours	6-18	h, Day, Yea -1911	Hanso	onville	,Va.
	aryland show	_	10a. State 10b. County	C-	10c. City, Town or Lo						10d. Inside City 1 ☐ Yes	
	r 28a-f	irecto	Md. Balto 10e. Street and Number		Roseda	10f. Zip Cod	0		10g. C	citizen of What Co		<u>X</u>
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920	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show Visel Examinet must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married *Uniform Widowed 4 □ Divorced	Armed Force	:: 13.	1 ☐ Yes 2 1		gin? (Specify Yes , Puerto Rican, etc	2.)	Black, White Specify: White	e, etc.	
1215-0		Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	dent's Usuai Oci kind of work do DO NOT use rei emaker	cupation ne during most tired)	of working	16b.	Kind of Business/	Industry	
Maryland 21215-0036	should be filed within and Mental Hygiene. marked other then 'matic event, Itu Me	To Be Co	12th 17 Father's Name (First, Middle, La John W. Perry	st)	17011	- Chiarter	18. Mothe	r's Name <i>(First, M</i> Nanni	iddle, Maide e Bool	an Sumama)		
Mary	s 1 and 2 should f Health and Men item 27 is marke other treumatic	-	19a. Informant's Name/Relationship	(Type, Print)						or Town, State, 2	lip Code)	
Baltimore, 1	Pages 1 and nent of Health snt: If item 27 ury or other t		Judith L. Shirk 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Dispo	osition (Name of matory or other)	place)	Rosedale Date 4-3-2008	20c.	L23/ Location - City or Balto, Md.		
Baltir	permit. Pages Department of Importent: If it any injury or c		21. Signature of Funeral Service Lic	•		2. Name and Ad chimu nel			9705 I	Belair Ro	1.	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that causely one cause on each	n line,	1	/			` _	Approximate Interval Betw Onset and D	ween
	Pnysician /Medical		disease or condition resulting in death)	aDue to (or	as a consequence of):	erotic	, 100	u c	lisa	isl	1000	-
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Y	icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a consequence of);							
,8760,	icate be physicia s the bur	edical		d								
P.O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown		2 □ Fetal death 3 [t at time of death 5 [□Ectopic pregna □ Other (s <i>pecify</i>				23d. Date of del Month		/ear
	quires that the de on signed by the a uld be detached t	by	Part II. Other significant condition:	contributing to death	(A) " //"	underlying cause	given in Part I.	236.	Did tobacco	o use contribute to	the cause of decorably 4 U	
il Records,	The ate has page	Completed			<i>U</i>			24a.	Was an autopsy performed? Yes 2	prior to death?	itopsy findings a completion of ca	available ause of
Vital	Physician: Tripis certificated director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 ER/Outpatie	nt 3 DOA	Othor	of Death (Check		6 □Other (Spe	cify)	
on of	After Une	lon; T	27. Manner of Death 1 Natural 5 Pending			of 28c. !	njury at Work? 1 □ Yes 2 □	28d. Des		jury occurred		
Division	or Atten ifter deat Director: in by the	Certification;	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determini	be 28e. Place of	Injury - At home, farm, st etc. (Specify)			28f. Loca	tion (Street or Town, Sta	and Number or Ru ate)	ural Route Numi	ber,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C			est of my knowledge, deals s of examination and/or in stated.)
	To the To the Comp	Ž	29b. Signature and title of certifier		/		ense number A OC	08	29d. [Date signed (Mont	h, Day, Year)	
,	5		30. Name and address of person wh	cushely o completed cause	of death (Item 23a) (Type				7.0	BALTI	0	2.0
F	Sta	te.	31. Date filed (Month, Day, Year)	A ((32. Beg	105 FP. istrar's Signature	HNKLI	N 24	LUARE	レドー	, DAL (7)	TORF,	MU
	Registi		APR 0 3	2008	us to A	anti						

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08-02423 Donald L Bryant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 27, 2008 1331 hrs Medical Examiner Bryant Donald L. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Allegany Western Maryland Health System - Braddock Campus Cumberland 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Davs Hours Director 578-78-5100 OCT 23 1960 Country) D.C. 47 1 XM 2 F Yrs Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Eckhart Mines Allegany MD 10g. Citizen of What Country? 10e. Street and Number notified at 21528 1503 Eckhart Mines Street, Apt. C2 Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noother than "natural", or Items the Medical Ex-miner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 2 X No Yes "natural", or Yes 2 X No specify: White If Yes. Give Yaar Specify: 3 Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within 72 Baltimore, MD 21215-0036 Self-Employed Carpenter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental H tant: If item 27 is marked or or other traumatic event, till event. Be Pear1 Green Bryan Bryant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Petersburg, WV 26847 Box 25, River View Addition, Pearl Smith - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 4/1/2008 Baltimore, MD Metro Crematory, Inc. ment ctant: 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee H. Williams ²²Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line 'Medical Death Verapamil Intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f per ME g878 4/4/08 amh attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death' 1 ✔ Yes 2 No No 1 🗸 Yes the Hospital or Attending Physician: ' hin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: this 1 V Yes ٩ 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No Pending To the Funeral Director: completely filled in by the Fnd 3/27/08 Fnd Unk AM Subject Invested drug 2 Accident Investigation 28f. Location (Street and Number or Jural Route Number, City or Town, StatePO Pox 19 Fickhart Mines 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be (Specify) Found Residence determined Allegany Co., MD 21528 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. March 28, 2008 nn 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 0 3 2008 32. Registrar's Signature State Mary Commenced Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary 1276 4.5878 White 68 JA Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Martha O. Branch 3 1:10 a M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto 1518 N. Broadway 5. Social Security Number 70 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 🛛 F Months Hours 216-20-Director 6320 2-21-1928 80 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment if them 21 is marked other than "natural" or flome many Injury or other trainment. 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits Director N/A 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1518 N. Broadway 21205 Funeral S Α 12. Was Decedent Ever in U.S. Armed Forces? 1 [Zives 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ Specify: Black XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Program Director Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan C. Irby, Rose Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21205 Marsha Branch- Daughter 529 N. Robinson Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State #☐ Donation 5 ☐ Other (Specify) 4-3-2008 Baltimore Nat Balto, MD 21. Signature of Europal Service Licensee 22. Name and Address of Facility March F/H East N Avenue Balto, MD North' mes 1101 23a. Part1. En / r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1A BETES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1-Natural 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35102 MAYCH 28, 2005 NUUUU (YM M O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Invit Dant m-D. 5901 Novith CHAVLES Street Balfimore Mayland

State Registrar

Day,

DHMH 17 Rev 1/2001

Robert Carroll Baker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) ROBERT CARROLL 3. Time of Death Physician/ BAKER March 26, 2008 0900 hrs Medical Examiner EL V c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Rossville Franklin Square Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 5 Speial Security of lumber 8-29-1947 Days Hours Min. Months Director Country) 218 48 2681 -66- Yrs. MD 1 🗴 M 2 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location Yes 2 X No NC BRUNSWICK CALABASH 28a-f show death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 831 NICHOLAS DR SW 28467 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes 2 WHITE If Yes, Give Year VIETNAM 1 Yes 2 X No specify: Specify Widowed Divorced è 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed yes 1 and 2 should be filed within 72 h of Health and Mental Hygiene. If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 TRUCK DRIVER YELLOW FREIGHT 18 Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) (CARROLL) CHESTER BAKER MILDRED C. Be 19a. Informant's Name/Relationship (Type, Print)
KIMBERLY BAKER/WIFE ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NICHOLAS DR SW CALABASH, NC 28467 19b. Mailing Address (Str 831 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date permit. Pages 1: Department of H Important: If it crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 3-28-2008 CATONSVILLE, MD METRO CREMATORY Donation 5 Other Specify 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21 Signature of Funeral Service Licenses 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease ≒xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED ed by the attending physician detached for use as the burial AMENDED #5,7,8,perINF.,G878,4/17/08,WS cords, P.O. Box 68760, law requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Yea Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed? The Yes 2 No Nο this ce ificate 1 🗸 Yesc ttospital or Attending Physician: The within 24 hours after death.
To the Funeral Direct 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 27, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 15 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) APR 0 3 2008 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

Alvin Kirby Brunso		Please Typ St - For State			/ Depa	rtment o	of Health of Death						2	00	8 10	69
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Funeral	7	5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	ast birthday)	If Under		If Under		8. Date of	Birth(M	M/DD/Y	YYY) 9. Bi Forei	rthplace (State	or
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2121 uld be fil Mental I marked	╙┖	19a. Informant's Name/Relations		Print)		19b. Mail	ing Address	/Street	Erne	er or Ru	ral Route	Number	City or	Town, Sta	te, Zip Code)	00
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re, land land Healt Fitem		20a. Method of Disposition 1 Y Burial 2 Crematio	- 2 D	amount from St		Place of Disp crematory or	osition (Name other place)	of cem	etery,		Date	20	c. Loca	tion - City o	or Town, State	
Pages nent of ant: I	1	4 Donation 5 Other S		sillovar Irolli Si	Ki	ng Me	emoria	1 P	Park	4/5	5/08		Ran	dall	stown,	Md
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlal Hygien and Inportant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	hompse		22 М а И 3	Name and Acarch F BOO Wa	ddress d H	of Facility West	t ve.	Bal	timo	ore	, Md	2121	.5
Physician	7	23a. Part I. Enter the disease, o failure. List only one cause	r complicatio	ns that caused	the death	. Do not ente	r the mode of	dying, s	such as ca	rdiac or	respirator	arrest,	shock, d	or heart	Approxima Between (
'Medical xaminer	1	Immediate Cause (Final disease	e a. Mult	iple Injuries											De	ath
	-	or condition resulting in death)		o (or as a cons	equence o	of):										
	<u></u>	Sequentially list conditions, if any, leading to immediate		o (or as a cons	equence o	of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	€:	o (or as a cons	equence c	of)·		_								
		events resulting in death) Last	d.	3 (01 23 2 00113	equence e	2.7.										
. 	Physician/Medical	UNPENDED	_ AM	ENDED												
Box 68760, e death certificate be the attending physic ed for use as the bur	Ĕ,	IF FEMALE: 23b. Was decedent pregnant in		c. If yes, outco	me of preg	nancy								ate of deliv		
certification	إقا	past 12 months?	1 1	Live birth Pregnant a	t time of de	eath 5	Fetal death Other (Specif	3 <u></u>	Ectopic	pregnan	су		Mor	าเท	Day	Year
Box death	Š	1 Yes 2 No 9 Ur	nknown g	Unknown		0	Other (opean	<i>"</i> _								
cords, P.O. B. law requires that the d has been signed by the standard be detached	5	Part II. Other significant cond	itions conti	ributing to dea	th but not r	resulting in th	e underlying c	ause gi	iven in Par	t I.	23e. [to the cause of	
S, P											1040.1				- ,	Unknown
ord w req as bee	Completed						-				1	Vas an autopsy performe		prior to death	autopsy finding o completion of	cause of
Rec The la icate h	Ę											es 2	No	1 🗸		No
tal Rec	Re	25. Was case referred to medic examiner?	al Hospit	al:				- 7	of Death (Other			· De	-idense	6 🗸 Otl	es Coops	
n of Vi	<u>-</u>	1 Yes 2 No 27. Manner of Death		8a. Date of Ini	ent 2	ER/Outpati 28b. Time		^	y at Work?		Home 5				ier. Scerie	
Division of Vital Records, P.O. is or Attending Physician: The law requires that the realth redeath. Al Director: After this certificate has been signed by the thineral director, page 2 should be deach the control of the control o	Certification:	1 Natural 5 Per	nding	Mar 30, 200	Year)	1330 hrs			es 2	İF	Building	collap	sed o	n subjec	t	
ivisior or Attence after death Director:	[월		estigation Lid not be	28e. Place of I	njury - At h	nome, farm, s	treet, factory, o	office bu	uilding, etc						Rural Route Nu	ımber, City
Division piral or Attencours after death eral Director: filled in by the	틽	4 Homicide det		(Specify) To	wnhous	se / Rowh	ouse			E	62 Wilso	on Stree	et, Balti	imore, MI)	
	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	aminer:On t	e basis of ex	amination a	dge, death oc and/or invest	ccurred at the tigation, in my c	ime, dat opinion,	te and pla death occ	ce, and ourred at	due to the the time,	cause(s date and	and mad place,	anner as s and due to	tated. the cause(s)	
To wit To COM	ğ	29b. Signature and title of certif		manner stated			29c.	License	e number			2	9d. Date	signed (/	Month, Day, Yea	ar)
9 6		/ //	/(_				O.C.N	M.E.			٨	March	31, 200	8	
OCME		30. Name and address of person Mary G. Ripple MD.		eted cause of Chief Med			111 Penn S	Street,	, Baltimo	ore, M	D 2120	1				
Sta	te	31. Date filed (Month, Day, Year		32. Registr		ture 🎤	ule									<u> </u>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician Estlin Edward Bryan 10.13 PM MARCH 20 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/Á 8. Date of Birth Month, Day, Year) BALTIMORE HOSPITAL SAINT AGNES 7. Age (In yrs. last birthday) 81 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1XM 2□F 217-22-8597 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 □Yes 2 No notified Lansdowne Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 21227 10e. Street and Number 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 114 4th Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give 1 0 / 5 ⊆ 11 Marital Status within 72 hours after 1 □ Never Married 2 Married White If Yes, Give Year or Dates: 1945-46 1 ☐ Yes 2 X No Specify: altimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Draftsman Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be fill lealth and Mental H m 27 Is marked oth Be Genevieve Miller Howard Bryan 2 19a. Informant's Name/Relationship (Type. Print)
Penny Louise Darciprete, daughter 19b. Mailing, Address (Street and Number or Rural Route Number, City or Town, State Zin Code) Cer 3403 Shannon Dr. Baltimore, MD. 21213 permit. Pages 1 and 2::
Department of Health at Important: If item 27 Is any Injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 04-3-08 Elkridge, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOWER GASTROINTESTINAL DAY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ARTERY DISEASE 24a Was an CORONARY autopsy performed? 1∏ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Injury the Hospital or Attending vin 24 hours after death. 1 Natural 5 ☐ Pending investigation in 24 hours are the Funeral Director: After Funeral Director: After Funeral Director: After Funeral filled in by the fune 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 22253 MARCH 30 2008

State Registrar DIMAN

31. Date filed (Month, Day, Year)

03

4+1

DHMH 17 Rev 1/2001

900 CATON AVENUE BALTIMOLURE, NID 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMIC HHANE, MID

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** $\underline{\mathtt{A}}^{\mathsf{M}}$ Margaret J. April Brockman 2008 5:39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2XX 19, 74 1933 Washington, 579-42-8128 Aug. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2424 Seibel Drive r death v 20905 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: MXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced er than "natura the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. Int: if Item 27 is marked other than "nat Iny or other traumatic event, the Medica (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Government Ø 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Eugene Brockman Margaret Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other tra Sandra L. Martin/Cousin 16001 Kerr Road, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XIBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/4/2008 Suitland, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licensee JM01103 313 Talbott Avenue, Laurel, 20707 Approximate Interval Between Onset and Death 23a. Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedi le Cause (Final disease o condition **Physician** Arteriosclerotic Cardiovascular Disease over 1 year resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of iner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed Exam physician and sthe burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed' 1 Yes 2√2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 🗌 Inpatient 2 X ER/Outpatient 3 DOA funeral dir Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 X Natural М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined XX-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 4/1/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Syed Sadiq, MD 14333 Laurel Bowie Road, Suite 208, Laurel, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 0 3 2008

P.O. I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10699

			1- For State Registrar Cert	tificate o	f Death		Re	eg. No.	0 1000
	Physici	an/	Decedent's Name (First, Middle,Last)				2. Date of Dear Month	Day Year	3. Time of Death 0332 hrs
	al Exami	ner	Mason Ryder Brown Aa. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location o	March 30,	2008 4c. County of Dea	
			Harbor Hospital		Baltimore			N/	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. la	ist birthday)	If Under 1 Year			th (MM/DD/YYYY) 9. E	
	Director		215 81 5187 1XM 2 F	Yrs	Months Days	Hours	Min. 03/12/	2008	CountryMaryland
	, A		Usual Residence of Decedent	Town or Local					10d. Inside City Limits
	ow any		1 1 1 D	altimor					1 Yes 2 X No
)	faryland 28a-f show I at once.	햠	Maryland Anne Arundel Ba		10f. Zip Code			0g. Citizen of What Co	untry?
	215-0036 be filed within 72 hours after death with the Maryland mall Hygiens maint Hygiens than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once ent, the Medical Examiner must be notified at once.	Director	114 West Hilltop Road		21225	5		U.S.A.	
5	with t ns 23a be not	eral	11. Marital Status 12. Was Decedent Ever in U.				in? (Specify Yes or No		erican Indian, Black,
	death or iter	Fune	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No				Puerto Rican, etc.)	White, etc.	
	s after ral", niner	by	3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No		kind of work done	Specify: WI	nite s/Industry
	2 hour "nate	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		nost of working life.				S/III dd dd y
	5-0036 iled within 72 hou Hygiene. I other than "nat	nple	0		Infant			N/A	
	5-0 lled w Hygie I other	ပ	17. Father's Name (First, Middle, Last)				's Name (First, Middle,		
	21215-0036 buld be filed within 72 I Mental Hygiene. marked other than 'cievent, the Medical	Be	Jeremiah P. Brown 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	a Address (Stree		Tiffany Mui		ate Zin Code)
	Baltimore, MD 21215 permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of hijury or other traumatic event, til	To	William Stankiewicz /Grandfather						yland 21225
	e, N 1 and 1 Health item		20a. Method of Disposition 20b. F		sition (Name of cer		Date	20c. Location - City	or Town, State
	MOF Pages ent of nt: If		I Dullal 2 / Clemation 3 Removal non State	-	Crematory	y	04/01/2008	Baltimor	e, Maryland
	Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Sig are o Funeral Service Licensea	22.	Name and Address	of Facility	Gonce Fur	neral Servi	ce, P.A. ryland 21225
			23a. Part I. Enter the disease, or complications that of used the death.						Approximate Interval
	hysician Medical		failure. List only one cause on each line.					est, shock, or hour	Between Onset and Death
,	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplain		II HI HEAR	Jy OL o	a restate		
		L	Sequentially list conditions, b						
		nine	If any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause c.	t):					
11	d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	f):					
V	ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redeath. redeath. the this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit		X UNPENDED X AMENDED 23a, per	ME,988	0 6/9/08 TI			-	
	60, ite be hysicia e buria	Medical	X UNPENDED AMENDED #23a,27,28a=f, point 23c, if yes, outcome of pregions	erME,g88 nancv	0 6/5/08 T	Γ		23d. Date of deliv	ery
	687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	2 F	etal death 3	Ectopi	pregnancy	Month	Day Year
	Box 68760, e death certificate be the attending physic of for use as the burn	Physician.	1 Yes 2 No 9 Unknown 9 Unknown	satn 5 O	ther (Specify)	-			
	that the death certife red by the attending detached for use as		Part II. Other significant conditions contributing to death but not re	esulting in the	underlying cause	given in Pa	art I. 23e. Did t	obacco use contribute	to the cause of death?
	sords, P.O. law requires that that bear signed by 2 should be detacted.	d by					1Ye	s 2 No 3 P	robably 4 🗸 Unknown
	ords w requ s been should	olete		_			24a. Was auto	osy prior t	autopsy findings available o completion of cause of
	tal Recolision: The law certificate has ector, page 2 sl	Completed						ormed? death	
	of Vital Records, or Physician: The law requir wher this certificate has been someral director, page 2 should I	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpution 2			of Death Other	(Check only one)		
	f Vi Physi er this ral dir	2	1 Ves 2 No Inspired 1 Inpatient 2 V 27. Manner of Death 29a. Date of Injury	ER/Outpatier 28b. Time of		ry at Work	Nursing Home 5	Residence 6 Ot	her:
	ion of tending Ph eath.	ertification:	1 Natural 5 Dending (Month, Day, Year)		10	Yes 2 X	. 1	,,	
	Division tal or Attendir rs after death. al Director: Alled in by the fu	ficat	2 Accident Investigation Fnd 3/30/2008 3 Suicide 6 X Could not be 28e. Place of Injury - At he	FNd 2:5 ome, farm, stre		ouilding, e			Rural Route Number, City
	Divis Hospital or At 24 hours after d Funeral Directely filled in by	Certi	4 Homicide determined (Specify) found at	home			or Town,	Hilltop Rd. B	rooklyn. MD
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1 Certifying Physician: To the best of my knowled: (Check only one) Medical Examiner: On the basis of examination a	ge, death occu	urred at the time, d	ate and pla	ace, and due to the cau	se(s) and manner as s	tated.
	To the within To the comp	Medical	29b. Signature and title of ceptifier		29c. Licens			29d. Date signed (
			Call III	_	O.C.			March 30, 200	-
	d		30. Name and address of per In who completed cause of death (Item	1 23a)					
	Ø		Jack Titus MD. Deputy Chief Medical Examiner		nn Street, Bal	timore,	MD 21201		
	S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire freats	,				
DI	HMH 17 Rev 1/2		AFR V 3 (U00)	ÓRIGINA	<u> </u>			OC	ME
	CME 2006			CURIN	~ _				

Anton Bunch Darius 08-02565 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Darius Anton Bunch Month Medical Examiner 0123 hrs April 1, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Director Months 216-82-0649 2 F 32 April 17, 1975 MD 1xx M Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Baltimore b filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 952 N. Franklintown Road 21216 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes 2 X No Black 3 Widowed 4 Divorced If Yes, Give Year Yes 2 XX No specify: Specify. \$ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 12 laborer construction company of Health and Menial Hygiene. other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jerome Bunch Be Drusilla Sellers Pages 1 and 2 should ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drusilla Bunch / Mother 952 N. Franklintown Road; Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ore. Date crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State Department c 04/07/2008 Arbutus Memorial Park Baltimore, Maryland Baltim Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 23a. Part I. Executive disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wounds of Head and Shotgun Wound of Torso Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause Directo (or as a nonsequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed ian/Medical tending physician are use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death Physic 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other 4 Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 ✔ Yes Other 28a. Date of Injury (Month Day Year) Apr 1, 2008 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural 0045 hrs 1 Yes 2 ✔ No Pending the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 800 block N. Franklintown Road, Baltimore, MD determined (Specify) Local Street 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 1, 2008 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32. Registrar's Signature PRASE. U C Stables Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTFW/20b.c.perff. C878 4/10/08 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner Greneral PAMORE land 9. Birthplace (State or Foreign Country)
NORTH (AROLINA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day Year) 1 A V 29, 19 Age (In yrs, last birthday) **Funeral** Months 1 M 2 X F 243-36-1296 Yrs. Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director MARVLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 14. Race - American Indian. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) OTHGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DALTO. Date 20b Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) BALTIHORE, MYD 21. Signature of Funeral Service Licensee TR. FUNERAL HOME BALTO.MD 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 🗀 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate by completely filled in by the funeral director, page 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/0 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatule and title of certifier e of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

APR 03

2008

1. Decedent's Name (First, Middle, Last)

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Year

0815 A^M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2X No

Maryland

Month

DHMH 17 Rev 1/2001

6

Registrar

State

1. H A. Steinneh

APR 0 3 2008

31. Date filed (Month, Day, Year)

MS

State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Norma L. Conner 11:48PM APRIL 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL GOOD SAMARITAN BALTIMORE If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Minnesota 1 ☐ M 2 💢 F Yrs Director 469-32-4900 4-1-2008 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Md. Balto. Co. Director Rosedale 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5002 Shirleybrook Avenue 21237 Funerai filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3√ Widowed 4 Divorced X White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Depertment of Health and Mental Hygie
Important: If Item 27 is marked other ti
any lighty or other traumatic avent, the 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bert Moe Bertha Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Conner 8588 Manorfield Rd. Balto.Md. 21236 Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other pla Gardens of Faith 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-5-2008 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Dias Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed STABE DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 ₩ 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 □ Ippatient 2 □ ER/Outpatient 3 □ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time ol 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. I Diractor: A 6 Could not be determined 281. Location (Street and Number or Rural Roule Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dira 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MEDICA ATTENDEY DOOG2239. APRIL 5 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) MAW WHI NG OO, MD

DHMH 17 Rev 1/2001

State

Registrar

HOSPITAL

BALTIMORG

SAMAKITAN

32 Registrar's Signature

600D

APR 0 3 2008

31. Date liled (Month, Day, Year)

			State of Maryland				lental Hygie	ene		
			■ Registrar	Cer	tificate of D)eath		No. 201	18	10704
- 13	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day	/ear	3. Time of Death
	/Medic		Ronald Anthony Cucina		* 60 T	Landing of Booth	4-1-2008	4a Oswati at	(D II)	6:45A "
ğ :	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location or Death		4c. County of		
			9010 Kilbride Rd. 5. Social Security Number 6. Sex 7. Age (In yrs. las	st hirthday)	Balto.	If Under 24 Hrs.	8. Date of Birth		to.Co	ace (State or Foreign
н	Funeral Director		219-40-1193 1X M 2 F 66	Yrs.	Months Days	Hours Min.	(Month, Day, You 3-27-194	ear)	Count	try)
1.	997		Usual Residence of Decedent				3-27-194	4	riu.	
	rylan how	_	10a. State 10b. County 10c. City,	Town or Loc	ation				10	Od. Inside City Limits
	e Ma 3a-f s tiffiec	cto	Md. Balto. C.	Bal	to.					1 ☐Yes 2 No
	er th	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of Wh	nat Coun	try?
	ath w		9010 Kilbride Rd.	1	21236			USA		- La d'an
	er de items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	White,	
36	rs aft	by F	1 ☐ Never Married	1	☐Yes 2x No	Specify:		Specify:	W	nite
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at	ed	15. Decedent's Education	16a. Deced	ent's Usual Occupa	ation	16	b. Kind of Busi	iness/Ind	ustry
15	nin 72 n "na Medik	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	kind of work done d OO NOT use retired)	uring most of worki	ing			
212	d with giene sr tha the I	E		Civil	Engineer		U.	S.Armv	Cor	. Engineers
	e file al Hy othe vent,	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Ma			
<u>a</u>	uld b Menta arked	70	Anthony J. Cucina			Josephi	ine Lazza	ro		
Maryland	2 should and Mer is marke aumatic	·	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Rura	al Route Number, C	City or Town, S	tate, Zip	Code)
	and ealth m 27		Andrea P. Cucina Wife	9010	Kilbride	Rd. Balt	o. Md. 2	1236		
9	Pages 1 nent of H int: if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Dispos netery, crem	sition (Name of natory or other place	9)	Date 20	c. Location - C	ity or To	wn, State
altimore,	: Pa tmen tant: ijury		4 ☐Donation 5 ☐ Other (Specify)	view		4-5-2	2008	Fallsto	on, l	1d.
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22	. Name and Addres		1 17	070E B	7	. D.1
		_	23a, Part1. Enter the disease, or complications that caused the death.	Do not ente			al Home		етаті	Approximate
	2		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Do not onto	or are mode or dying	g, odori do odraldo i	or respiratory arrest	1		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	reer						13 months
	Examiner		Due to (or see conseque	rice or):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underwin.	ence of):					_	
λ.	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
်	execan an an irial-tr		resulting in death) Last Due to (or as a conseque	ence of):						
8760,ঙ	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be defached for use as the burial-transit	dical	d						_	
9	ertificating plants to a set a	Mec	IF FEMALE:							
. Box	leath certific attending p	ian/	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal of	leath 3	Ectopic pregnancy			23d. Date Mont		ry Day Year
	he de the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown	ath 5∐	Other (specify)					
٦.	that the de led by the a detached i	Ph.	Part II. Other significant conditions contributing to death but not result	ing in the un	derlying cause give	n in Part I.	23e. Did tobac	cco use contrib	oute to th	e cause of death?
Vital Records, P.O	w requires tha s been signed I should be det	d by					1 th yes	2 □ No 3	B 🔲 Prob	ably 4 ☐Unknown
Ö	w req	Completed					24a. Was an	24h W	ere autoi	osy findings available
Ř	he lav e has	ш					autopsy performe	d? de	ior to cor eath?	npletion of cause of
g			25. Was case referred to medical			26. Place of Deatl	1 Yes 2 1 (Check only one)		Yes	2 No
	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient	3 DOA Othe	P.	me 5 Residence		(Specify	·)
Division or	iding Phy th. : After this funeral d		21 4 5 14 1	28b. Time of Injury	28c. Injury Work		28d. Describe how			<u></u>
Ö	ath. or: Af	atio	2 Accident investigation			res 2 □ No				
≝	or Att ter de irecte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number State)	r or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director,					1				
	Hosp 24 hou Fune tely ti	Medical	29a. Certifier (Checkonly and Medical Examing): On the basis of examination and mapper stated							
	ithin 2 o the	Med	one and manner stated. 29b. Signature and fitte of gertifier		29c. License	number	291	. Date signed	(Month.	Day, Year)
	F 3 F 8				The de	EKill.	5	4121	2 6	<i>y</i> , <i>y</i>
	(.		30. Name and address of person who completed cause of death (Item 2	23a) (Type 1	Print)	000CC	J	9	00	
	V		Mouth T. Fole Man. 22 S	(a Co	ene St	Bull	what a	mD	217	01
	Sta	te	31. Date filed (Month, Day, Year) 32. Hegistrar's Signatu	ire	1 40	· · · · · · · · · · · · · · · · · · ·	1111111		NIO	V
	Registr	ar	APR 0 3 2008	F A	naves)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Year **Physician** Eileen D. Cook 03-28-2008 0857_P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1007 N. Tollgate Rd BelAir If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01-21-1954 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months 1 ☐ M 2 🔀 F 54 Director 215-50-2122 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 N. Tollgate Rd 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 +Consultant Cosmetics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Quinn Rosemary Kalus 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Cook (Husband) 1007 N. Tollgate Rd Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Highview Mem. Gar. 03-31-2008 Fallston, MD 22. Name and Address of Facility Schimunek Funeral Home of 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2□ No Division or Vital 1□ Yes To the Hospital or Attending Physician Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After ospital c. 24 hours after deau.. real Director: After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 29a. Certifier (Check one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Narch 31-1. 2008 and title of certifier 29b. Signatu 38. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atword Road #200, Bel Air, MD2104 0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

		1	For State Registrar	State of M	laryland		artment of <i>rtificate of</i>	Health and I Death	Mental Hy	giene Reg. No	711118	10706
			Decedent's Name (First, Middle, Las	it)					2. Date of De Month	eath Da	ay Year	3. Time of Death
	Physicia /Medic		David Hawley Caun	ter					March			13:05 ™
	Examin	4	4a. Facility Name (If not institution, give)		4b. City, Town,	or Location of Death	1		c. Counfy of Death	
		×	Shady Grove Adven				Rockvill				ontgomery	
- 1	Funeral		5. Social Security Number 6. S	ex 7.A ⊠M 2□F		a <i>st birthd</i> ay) Yrs.	If Under 1 Yea Months Days		8. Date of Bi (Month, Di April 2	rth ay, Year O 1	927 Ohio	place (State or Foreign ntry)
	Director		287-22-1410 'Usual Residence of Decedent		80	110.			APLITZ	J, 1	927 01110	
	land it		10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	Mary -f sho ied a	to	Maryland Montgome	ry	Rock	ville						1 X Yes 2 ☐ No
-	r 28a	Director	10e. Street and Number		1		10f. Zip Code				itizen of What Cou	
	n with		620 Great Falls R	oad			20850				ted State	
	d within 72 hours after death with the Maryland glene. It than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or N to Rican, etc.)	0-	 Race - America Black, White, 	
ð,	or it		1 Never Married 2 Married	1 X Yes 2 ☐ If Yes, Give] No		1 □ Yes 2 K N			Ì	Specify: Whi	ite
9500-61212	hours ural"	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates	: WWI		dent's Usual Occ	unation		16b. 1	Kind of Business/In	
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ore	Pages 1 nent of H int: If Iter iry or oth	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	e Mary	emetery, cre V Land	osition (Name of matory or other p Veterans	(açe) Apri	.17,		,	
	tmen tant: tant:		4 □ Donation 5 □ Other (Specif		Ceme	eterv	at Crown	isville 2	2008	Cro	wnsville,	Maryland
Baltimore,	permit. Pages 'Department of the important: If Ite any injury or of once.		21. Signature of Funeral Service Licen		100896	30	00 W. Mo	ntgomery .	Ave., R	ockv	me/Rockvi	ille, Inc. 20850-2805
			23a. Part1. Enter he disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caus one cause on each	ed the death line.	n. Do not en	ter the mode of d	lying, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death 2 weeks
	Physician / /Medical		disease or condition resulting in death)	a. Pneumor	nia as a consequ	uence of):						Z weeks
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8760,	icate be executed physician and s the burial-transit	dical		d								
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. Box	eath c attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Feta	I death 3	⊒Ectopic pregna ⊒ Other (specify)				Month	Day Year
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown								
Vital Records, P.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions						23e. Did	d tobacco	o use contribute to	the cause of death?
<u>rd</u>	quires in sign	d by	Diabetes, Obesity	y - Hypov	entila	tion	Syndrome		10	Yes	2 ™ No 3□ Pro	obably 4 □Unknown
ပ္သ	s bee	lete							24a. Wa	as an topsy	24b. Were au	topsy findings available completion of cause of
E E	The la	Completed							pe 1□ Yes	rformed?	? death?	2 □ No
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<u>-</u>	hysic nis ce I direc	To E	1 Yes 2 No	Hospital: 1 🔼 Inpa	atient 2		III 3 DOA		_		6 □Other (Spec	cify)
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Division or	or At after d Direc in by	Certification:	4 Homicide determined	Zee. Flace of	etc. (Specif	fy)	treet, factory, offi	oe .	City or 7	Fown, Sta	ate)	ia riodic ivamoor,
	To the Hospital or Attending Physician: The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 11 CertifyIng P	hysician: To the be	st of my kno	owledge, dea	th occurred at th	e time, date and place	ce, and due to the	he cause	e(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exa	miner: On the basis	s of examina	ation and/or i	nvestigation, in n	ny opinion, death oc	curred at the tim	ne, date a	and place, and due	to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of dertifier	1			29c. Lic	ense number			Date signed (Monti	
			Jak Ar	bourker,	1 (MM	, I	26540		Ma	rch 28, 2	2008
	15+1		30. Name and address of person who	completed cause of	of death (Iten	n 23a) (Type	, Print)	D.1 #010	00441	w.c.L	Maren	1and 20977
	12,		Carl I. Schoenbe	127			ederick	Ka.,#213,	, Gaithe	:rsD1	urg, Mary	200//
	St	ate	31. Date filed (Month, Day, Year)	32. Regi	istrar's Signa	aiure	des					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** ARRI 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 51LCHRIS; LENTER HOSPICE If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Year) Min 1 M 2 □ F Months Days Hours 214-38-0239 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ins. Modical Examiner must be notified at 1. ✓ Yes 2 No Director MARYLAND 10g. Offizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2. No Specify Specify: ģ Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) CITY OF BALTO STODIAN 12 HGRADE 18. Mother's Name (First, Middle, Maiden Surhame) (MN - UNKNOWN) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be WILLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Pral Route Number, City or Town, State, Zip Code) BALTO, DEMINDS HRISTEVEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-05-08 4 Donation 5 Dother (Specify) LANSDOWNE, MARYLAND CEMETARY 22. Name and Address FUNERAL HOME 21. Signature of Funeral Service Licenses PH H. BRO. N. FULTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancinom/ /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine physician and s the buriat-transit Invavenors Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 💆 No 3 Probably 4 Unknown 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 □No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No death. 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide E-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

The law requires that the death certificate be executed 68760, Box Ö σ. of Vital Records, Hospital or Attending Physician: completely filled in by the funeral director, Division within 24 hours after death To the Funeral Director:

3altimore, Maryland 21215-0036

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles SI NES MS 31. Date filed (Month, Day,

State Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 1, 2008 12:55 A M Louis Wilson Doyle April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Months Hours Min. 1 M M 2 □ F 15, Director 717-07-7788 89 Nov. 1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Baltimore 1 ☐ Yes 2 No Maryland Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 1005 Woodsdale Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:1 940-45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Clerk Railroad 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Carl Doyle Blanche Mary Rest 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret R. Doyle Wife 1005 Woodsdale Road; Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4/4/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lizens len 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the 1 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** usmlar /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error and raying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩hknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2□ No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 ☐ Yes SE No Hospital: Other: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To Allursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond Miller Strut Surte 31 Date filed (Month, Day, Year)



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day NGELKE Month Year **Physician** ellie 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospita 5. Social Security Number 6. Sex 7 7. Ad OSECIAL er 1 Year | If Under Center timore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F 90 Director 220-05-8845 5-31-1917 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at MD BALTIMORE RASPEBURG 1 ☐ Yes 🎾 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8503 HANF AVENUE 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: WHITE 3☐Widowed 4☐Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Is marked other than College (1-4or 5+) PACKING **ESSKAY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I **EDWARD** MC FAUL J. NELLIE (EVANS) ု and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum KENNETH ENGELKE/SON 8503 HANF AVENUE BALTIMORE, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 4-3-2008 BALTIMORE, MD 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records. þ 1 ☐ Yes 2 ☑ No Dementia, Polymualaia 3 Probably 4 Unknown arremia, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate ulce Stage 4 1□ Yes 2 1100 funeral director, 25. Was case referred to edical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Division or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29c. License numbe 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) 0000 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 3 32. Registrar's Signature , 9000 Franklin Square Drive, Baltimore MD, 21237 DriAdanna Njoku 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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21215-0036 of within 72 hours at giene.		eg eg	15. Decedent's E (Specify only highest gro	ducation	16a.	Decedent's Us	ual Occupation	n ng most of wor	ung N/A	16b. Ki	nd of Business/	Industry	N/A
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10re, Maryland 21215-0036 ges 1 end 2 should be filed within 72 hours after deeth with the Marylan it of Heath and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-1 show		<u> </u>	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	ss (Street and	Number or Ru	ral Route Num	ber, City o	r Town, State, 2	(ip Code)	
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Baltimore, Maper permit. Pages 1 end 2 Department of Health at Important: If item 27 is	ony in		21. Signature of Funeral Service Lice	nsee	1		and Address o	25000 550	March			2	1202
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I Records, P.O. Box 68760, The law requires that the death certificate be executed ste has been signed by the attending physician and		lica l		s. d			* ***						
× 6	20 25	Pnysician/med	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of del	ivery	
Box eath cert		cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic 5 ☐ Other (Month	•	Year
P.O.	ache	S	1 ☐ Yes 2 ☎ No 9 ☐ Unknown	9□ Unknown							03 8	14 20	08
S that		2	Part II. Dther significant conditions	contributing to death b				in Part I.	23e. Dio	tobacco i	use contribute to		
cords w require		9	Premature	delivery	1 6 21	week	>		1	Yes 2	Øno 3⊟Pr	obably 4 🔲	Jnknown
law re	L'S N	Completed by							24a. Wa	opsy	prior to	topsy findings completion of c	available ause of
The standard	bad	5							1 Tes	rformed? 2/ZINo	death? 1 ☐ Yes	2 × No	
of Vita Physician: r this certifica	a cror	e n	25. Was case referred to medical examiner?	Hospital:			Other	6. Place of Dea					
Phys.		2	1 ☐ Yes 2 € No 27. Manner of Death	1/28Linpatie	ent 2 EP/Ou	tpatient 3 l	JUA		ome 5 ☐ Re 28d. Describ		6 □Other (Spe ry occurred	cify)	
On ding			1☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) li	njury M	28c. Injury at Work? 1 ☐ Yes	s 2 18 No	1	1/A			
Division of Vital Records, I or Attending Physician: The law requires talter death. Director, After this certificate has been signed.	by the	20	3 Suicide 6 Could not to determined	28e. Place of Inj	jury - At home, fa	rm, street, facto	ory, office		28f. Location	(Street ar	nd Number or Re	ural Route Num	nber,
Division in a safe	0 0	Certification:	4 _ nomicide	building, et	tc. (Specify)	NIA			0, 0		NI	<u></u>	
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director, After this certificate has			29a. Certifier (Check only 2 Medical Exa	hysician: To the best miner: On the basis o	of my knowledge	, death occurre	ed at the time, on, in my opini	date and place ion, death occu	, and due to the	e cause(s e, date an) and manner as d place, and due	s stated. to the cause(s	5)
the hin 24	ibleid.	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		9c. License n				te signed (Mont		
다 ^높 다	8		N 0	+, attend	ing blas				· NA				
1		-	30. Name and address of person who			Type Print	200	7451	IVLV	1	0 1		
1		-	Daniela Mesh	Lat 5005	- 0	e Bei	Llane	e Cla	nksvil	le, n	124/08	29	
	State	е	31. Date filed (Month, Day, Year)		rar's Signature	9							
Re	gistra	r	APR 0 3 200	0 0 000	AN SE	3846							

DHMH 17 Rev 1/2001

			1 - For State Registrar amend #5	State of Marylan G878 Per FH (4/07/08					giene Reg. No. 2008	3 10711
3	Physici	an	Decedent's Name (First, Middle, I	_ast)				2. Date of De Month March	Day Year	3. Time of Death 8:25 A M
12/2	/Medic Examin		Gladys C. Fe			4b. City, Town, o	r Location of Dea		4c. County of Dea	
3	Examin	er	4519 Gregg Roa			Brooke			Montgon	nery
	Funeral		5. Social Security Number 6	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days				rthplace (State or Foreign
	Director		578-18-1 89 2	1□M 2 ⊠ F 87	Yrs.	Worters Days	riodis	August	12, 1920 Wasi	nington, D.C.
	pu ,		Usual Residence of Decedent	100 Ci	ty, Town or Lo	contion				10d. Inside City Limits
	anylar show d at	F	10a. State 10b. County							1 □Yes 2X No
	he M 8a-f otifie	Director	MD Montg	omery B	rookev				10g. Citizen of What C	
	with t	ä	10e. Street and Number	- 1		10f. Zip Code	2.2			·
	eath	Funeral	4519 Gregg Ro	a d 12. Was Decedent Ever in U	S 13	2083		Specity Ves or No	United S	
_	ter d item Iner	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	.0.	Was Decedent of H If Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)	Black, Wh	
215-0036	hours after death with the Maryland tura!", or items 23a or 28a-f show al Examiner must be notified at	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify: V	Vhite
Ž	2 hor	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	nation	arkina	16b. Kind of Busines	s/Industry
7	within 72 ene. than "na! he Medic	ed t	(Specify only highest selementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most or w d)	orking		
N	filed wi Hygien sther th ent, the	Completed		2	S	ecretary			Law Fin	cm
	0 7 0 5 0 F	Be	17. Father's Name (First, Middle, La	st)				,	e, Maiden Surname)	
<u> </u>	2 should be and Menta is marked raumatic ev	မ	Harry Lee Po		Т			abeth Ma		
Mar	12 sh h and is m raum		19a. Informant's Name/Relationship			•			ber, City or Town, State,	
ຍ ອ	1 and Health em 27 ther 1		Brian P. Feder 20a. Method of Disposition			Oak Tree		Date	ick, MD 217	
saitimore,	Pages nent of I ant: If ite ury or o		1 X Burial 2 ☐ Cremation 3	nemoval from State		osition (Name of matory or other place	1			
	permit. Pa Departmen Important: any Injury once.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic		rklawn	Memorial 1	Park Apri	1, 4, 2008	Rockville	e, Maryland
n D	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic once.		7.3.	M00896						ral Home/ Rockwille MD 20850
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physician /Medical cian and pnuial-transit	Examiner	23a. Part1. Enter the disease, or washock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury that initiated events resulting in death) Last	a. Chronic Obs Due to (or as a consequence) Due to (or as a consequence) C. Due to (or as a consequence)	tructi quence of): quence of):					Approximate Interval Between Onset and Death
P.O. BOX 987	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2⊠No 9□Unknown Part II. Other significant condition Pneumonia	d	al death 3[death 5[□Ectopic pregnanc □ Other (specify) _ underlying cause giv			23d. Date of d Month tobacco use contribute	Day Year to the cause of death?
5	requi	ted	FilediioiiIa					- '-	res 2 No 3 K	Probably 4 ☐Unknown
	2 55 29	Completed						24a. Was - auto perf 1∐ Yes		
VITA	Physician: this certific ral director,	Be o	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	I EB/Out-atio	nt 3 DOA Oth	or:	eath (Check only		
	Phy r this ral di	L.	27. Manner of Death	1 ☐ Inpatient 2 ☐	28b. Time o	of 28c. Inju	ry at		how injury occurred	necity)
SION	nding th. : Afte fune	tion	1 X Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury	Wor	rƙ? ∣Yes 2∐No			
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ertification:	3 Suicide 6 Could not determine	28e. Place of injury - At h building, etc. (Special	I ome, farm, st fy)	reet, factory, office		28f. Location City or To	(Street and Number or sown, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		Physician: To the best of my know caminer: On the basis of examined and manner stated.						
	To ti withii To ti comp	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signed (Mo.	nth, Day, Year)
)			1 Churte	daysus		D39	793		March 31,	2008
	e q		30. Name and address of person wi	no completed cause of death (Iter						
	U			Mays, M.D., 18		nce Phili	p Dr.,	#207 , 01:	ney Marylar	nd 20832
	Sta Registr		31. Date flad R Day Zavos	32. Registrar's Signa	aiu	J				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 3 Doris Barbara Farrow 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis Eldercare Knollwood Manor Anne Arundel Millersville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 07/27/1924 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F 219 18 2152 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 21 No Maryland Anne Arundel Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 305 Seward Avenue 21225 U.S.A. 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Stienkraus Catherine Dale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Doris Manser / Daughter 305 Seward Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 04/04/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce_Funeral Service, P.A. 21. Signature Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THEROSCLEROTIC CARDIOVASCULAR disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery in the past 12 months? 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **Z** No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

,0

"natural";

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

by

Completed

Be

Exami and physician Physician/Medical the attending p signed I þ Completed within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page Be ို Medical Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

KILBRIDES RD, BATIMORES, MD 21236

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1) 31136

29d. Date signed (Month, Day, Year)

5 State Registrar

31. Date filed (Month, Day, Year)

9005 ALLALE mo 32. Registrar's Signature

u how

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760,

/Medical **Examiner** or Attending Physician; The law requires that the death certificate be executed signed to funeral director, page 2 should this After after death Director: filled in by To the Hospital of within 24 hours at To the Funeral C completely

Physician

/Medical

Examiner

Funeral

Director

show

ns 23a or 28a-f show must be notified at

Examiner

23a

Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Iten
any or other traumatic event, the Medical Examiner.

permit. Page Department o Important: If any Injury or once.

Physician

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

death with the Maryland

State

Registrar

DHMH 17 Rev 1/2001

and manner stated.

death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** enner Mable /Medical City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 □ F 246 30 4339 87 jan.25,1921 N.C Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County an "naturai", or items 23a or 28a-f show Medicai Examiner must be notified at 1 ∑Yes 2 No BALTIMORE MD N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3102 CHESTERFIELD AVE. 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK If Yes, Give Year or Dates: ρ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) JOHNSON College (1-4or 5+) than Elementary/Secondary (0-12) MANUFACTURING CO. the SEAMSTRESS 10thDepartment of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental SAMUEL FENNER MANER MCDANIELS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LAMONT FENNER 4911 GOODNOW RD. APT.J (son) BALTO, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT.ZION CEMETERY Apr.5,2008 BALTO,MD. 4 ☐ Donation 5 ☐ Other (Specify) Ig a ture of Funeral Service Licensee 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME madene 1412 E PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** robable disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner helastatic cance Gordan Manager Security of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9∏Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 2 No page 2 s has certificate 1□ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 □ No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury After t Certification: (Month, Day Year) Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier alhlin 1)006008 of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
APR 0 3 2008 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** March 28, 2008 1550 Charles E. Griffith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 15425 Bramblewood Drive Montgomery Silver Spring 8. Date of Birth (Month, Day, Year, Oct. 20, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1XM 2□ F 1923 Washington, Director 84 577-24-3569 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State wohe in then "natural", or iteme 23a or 28a-1 ehov It e Medical Examinar must be notified at 1 Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 15425 Bramblewood Drive <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Worl If Yes, Give Year or Dates: War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married World 1 ☐ Yes 2 🛣 No Specify Specify: þ War II 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If Item 27 is marked other it
eny injury or other traumatic event. III.s 4 Electrical Engineer Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ward Willson Griffith, II Alice Nickles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roxana Hegarty/Daughter 20560 Neerwinder Street, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. April 3, 2008 Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signatural Funeral Service Licers Rockville, Rockville, Inc. 300 Maryland 300 West Montgomery Avenue and 20850-2805 M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 27 Years Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for se's consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ page 2 should be Hypertension 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia this certificate has autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Medical Certification: To 1

Yes 2

No 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury death. 1 Tes 2 No М I Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital Records, P.O. Box 68760, filled in by To the Hospital or Al within 24 hours after of To the Funeral Direc

Baltimore, Maryland 21215-0036

1	Roger Stevenson,	M.D. 64	410 Rockledge	Drive,	#200,	Bethesda,	Maryland
State egistrar	31. Date filed (Month, Pay Year)	32. Rec	gistrar's Signature	D.			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

Um

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D20535

29d. Date signed (Month, Day, Year)

March 31, 2008

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Calvin Gross James 03 31 2008 /Medical 8:50a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing
5. Social Security Number 6. Sex Home ${ t Baltimore}$ Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours 216-07-5134 Director 29 100 09 07 MDUsual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits **Funeral Director** NA Baltimore 1 LXYes 2 L No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21218 2700 North Charles Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes St☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: Black þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Freight Handler 12th grade 3yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isora Johnson William Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Gittings Ave, Baltimore, Md 21239 William H. Gross-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 4/5/08 Laurel, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West lume 4300 Wabash Ave, Baltimore, Md Anim peno 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner disease Equalitially for an action of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an has page 2 autopsy performed certificate No No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes VZ No 1 | Inpatient 2 ER/Outpatient 3□ D0A Certification: To this 28a. Date of Injury (Month, Day Year) 27. Maprier of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 24 within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21201 Dan 821 N. 31 Date filed (Month, Day, Year) Registrar's Signature State APR 03 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2: 10PM **Physician** March 30 2008 RAC /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 7. Age (In yrs. last birthday) N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 26, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 X F Months Maryland 219-88-1541 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be r 21222 **USA** 1742 Leslie Rd. Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cocktail Waitress Food Service other 1 it of Health and Mental Hyg If Item 27 Is marked other or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Lorraine McGavaney Richard L. Guarnera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
101 Charles St. Westminster, MD. 21157 19a. Informant's Name/Relationship (Type. Print) Ashley Kinslow, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crematory 3-3-08 Odenton, MD Department Important: If any injury o 4 Donation 5 Dother (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus. MD. 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 48 hours **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria o the Hospital or Attending Physician: The law requires that the death certificate be edical if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 DING 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident .hin 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide I 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Baltimore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1, Day 2008 Year **Physician** Elaine M. Gallagher 11:45 a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 7944 St. Monica Dr. If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** 1□M 2 F Months Days Month, Day, Year) August 8, 1948 Maryland 213-52-4941 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 7944 St. Monica Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Flooring Company Purchaser 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophia Krystofiak Leon Rynarzewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7944 St. Monica Drive, Dundalk, Maryland Husband James Gallagher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 7, 20a. Method of Disposition permit. Pages Department of Important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus Dundalk, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Sona ure of Functal Service Licens, e 21222 23a. Part1. Enter the disease or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1car Me disease or condition resulting in death) /Medical Due to (or as a conse uence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1☐ Yes 2☐ No 9☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) or Attending 5 ☐ Pending investigation 1 □Yes 2 □ No death. 2 ☐ Accident hours after death uneral Director: the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person MULA ana

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Registrar's Signature

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

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Sebastian John

31. Date filed (Month, Day, Year)

Funeral

Director

g physician and as the burial-tran attending p nse ed by the a certificate has t irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this condition the funeral dire

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perform 1□ Yes 2 2 **2** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 17/01/08 0005517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Boltmore MD 21224 3023

State Registrar tastern

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AMIND TIPM/5, periff C8/8,4/3/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Robert Harrison, Jr. March 24, 2008 10:35 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Joseph Richey Hospice Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 218-86-2805 Days Months Hours 43 June 15, 1964 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at N/A XXYes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 USA 1027 Cathedral Street Apt. 6H Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Stores Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Harrison, Sr. Regina C. Lynch 19a. Informant's Name/Relationship (Type. Print)
Yvette Harrison/ Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5434 Whitwood Road Baltimore, Maryland 21206 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel Cemetery 3/29/08 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home toarris 4210 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Dav in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide L⊊Certifying Physician: To the loest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mayner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 se of death (Item 23a) (Type, Print) Year) State Registrar

Harrison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** 28 200 8 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bal MY VV If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 219-50-7347 61 Jan. 10, 1947 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at 1XYes 2 No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21216 3107 Baker Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. i TyYes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Completed r than "natur, 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Western-Electric Co. Elementary/Secondary (0-12) College (1-4or 5+) Assembler 2 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floretta Johnson Charles Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m. any Injury or other traum: once. 3107 Baker Street Baltimore, Maryland 21216 Floretta Hill/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/4/08 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland Crownsville Veterans Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service/Ligensee erre 23a P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or plant failure. List only one cause on each line.

Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** rdiomyc Caguardiany first continued in fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed hranic 00 attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed' certificate 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 EB Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. DOOG218 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 28,2008

State Registrar 2000 west Battimere

2008

APR 03

31. Date filed (Month, Day, Year)

7

Baltimere, MD

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) Marciarita B Tovel, MD

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Desedent's Name (First, Middle, Last, 2. Date of Death Month Physician 2008 LODSEVA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General marylana immore Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 78-5886 1**⋝**M 2□ F Months SEPTEMBER 08, 1965 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 No Funeral Director +iMOLE /Aryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 21 ElsiNone USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner ma 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 If Yes, Give 1 Never Married 2 Married 2 No 5-0036 1 ☐ Yes 2 🗷 No Specify Completed by 3 Widowed 4 Divorced JACK 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Entertai tender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filk ment of Health and Mental H ant: If item 27 Is marked oth Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Clairidge Rd BALTIMORE, KONNIE MATYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3636 W. Furest PARK AVE 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Comstery DI 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BAITO MI Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ficiency Virus requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed?
Yes 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes / 2 ☑ No Certification: To 1 ☑ Inpatient 2 ER/Outpatient 3 DOA this 27. Man er of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, Hospital or Attending hours after death uneral Director: filled in by 24 hours a completely the

> State Registrar

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day,

APR 0

0

Mary

and manner stated.

MIRM.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0.3 28 am **Physician** THOMAS HOUCK NHOL 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rusedale

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Year | Aug. 2, 1917 5. Social Security Number 180 timere Cente 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) Pennsylvania **Funeral** XXM 2□F 90 176-03-2746 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 □ Yes 2√XNo Funeral Director Baltimore Parkville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8800 Walther Blvd 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 LTNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Never Married 2 Married White 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify. Completed by Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Electronics 0wner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H cant: If Item 27 is marked oth Alice Doyle James Andrew Houck Important: If Item 27 is marker any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 Rowland Drive Port Deposit Maryland 21904 David M Houck Son permit. Pages 1 and 2 Department of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Macremation 3 □ Removal from State Donation 5 □ Other (Specify) GreenMount Crematory: 4/7/08 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEUMENIA **Physician** piratten disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if my leading limited in mmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the 1 use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 42 Unknown 2 No 3 ☐ Probably 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X No After this certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1/2 Natural 28b. Time of Year) or Attending 5 Pending investigation 2 □ No 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 117 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0065094 3/31/08 Novilon 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Balthmore, Md 21237 Binh Na 31. Date filed (Month, Day, 32 Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / De <i>C</i>	partment of leartificate of	Health and <i>Death</i>		giene	8	10724
	0		1. Decedent's Name (First, Middle,	Last)				2. Date of De		3. Time of Death	
	Physici /Medi		Noela	В.	SEE.	fner		March	30,2008	Year	11:30P M
	Examir		4a. Facility Name (If not institution,	or Location of De	ath	4c. County	of Death				
			Franklin Woods	Nursing Home	<u> </u>	Roseda			Balti	.more	
	Funeral Director		214-01-2890	6. Sex 7. Age 1 ☐ M 2 ☐ XF	(In yrs. last birthda 91 Yrs.	Months Days			th 19, Year) 25,1916	9. Birthpla Counti Canad	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10	d. Inside City Limits
	daryl f sho	ō	Maryland Balti	more	Dune					.0	1 ☐ Yes 2 🛣 No
	288-	ect	10e. Street and Number	O.L.C		10f. Zip Code			10g. Citizen of W	/hat Count	
	3e or	Funeral Director	1916 Walnut Ave	nue		2122	22		USA	nat oount	
	death ms 2	era	11. Marital Status	12. Was Decedent B	ver in U.S.	. Was Decedent of I		(Specify Yes or No		- America	in Indian,
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Items 23e or 28e-1 show event, it e Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? d 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		If Yes, specify Cub 1☐ Yes 2\ \ No	oan, Mexican, Pue	erto Rican, etc.)	Black	k, White, e Whit	
S O	72 ho	Completed	15. Decedent's	Education		edent's Usual Occu			16b. Kind of Bus	siness/Indi	ustry
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2121	ed wil	Con	8 years			sembly Li	ne Worke	er	Westingh	ouse	
p	al Hy	Be (17. Father's Name (First, Middle, La	ast)				ame (First, Middle		3)	
<u>X</u>	S should be filed within and Mental Hygiene. Is marked other than sumatic event, Ita Mi	2	Frank Le May				Loretta	a Berret	tta		
Maryland			19a. Informant's Name/Relationshi Donald G. Hafne:			ling Address (Street Walnut A					Code) 222
<u>6</u>	thealth tem 27 other tr		20a. Method of Disposition			position (Name of ematory or other pla		ri ^{Date} 5,	20c. Location - (vn, State
Ê	Pages nent of I ont: If it		1 X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	Removal from State		ematory or other pla n Cemeter	-		Dundalk,		
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Fund I Service Li			Name and Addre	Funeral	Home Of	Dundalk,	P.A.	Land
	0.01 = 0 0l		Much	XX		/110 SOLI	ers Poli	nt Road,	Dundalk,	Md. 2	21222
			23a. Part1/Enter the disease, or c shock, or heart failure. List or	ny one cause on each line	9.			•	rrest,	1	Approximate Interval Between
	Physician		Immedial Cause (Final disease or condition resulting in death)	_ Cerebr	0 0050L	llar au	cci de	ut			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
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	akecu al-tra	Examin	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
8/60,	icate be executed physician and s the burial-transit	dicai									
QC QC				u.							-
X R R	death certific e attending p d for use as	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Пе.			23d. Date	of delivery	y
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		□Ectopic pregnanc: □ Other (specify) _	y 		Mon	th D	Day Year
J.	t the by the tache	hys	9 Unknown	9 Unknown				· · · · · · · · · · · · · · · · · · ·			
_	iaw requires that the de as been signed by the a 2 should be detached f	by F	Part II. Other significant condition	s contributing to death but	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contri	bute to the	cause of death?
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ပ္သ	has be ge 2 sh	Completed	Dnemja					24a. Was		ere autops	sy findings available pletion of cause of
r	The ate	Som	Cantel S	tenosis				perfo	rmed? de	eath?	
<u>I</u>	ysicien: Th	Be (25. Was case referred to medical examiner?				26. Place of De	eath Check only o			
20		2	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpati	int 3 DOA Oth	ner: 4 Nursing	Home 5 Resid	dence 6 Other	r (Specify)	
	ding Phys	ino in	27. Manner of Death ☐ Hatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	of 28c. Injur	y at		now injury occurre		
SION	Attendio death. ctor: A y the fu	cati	2 Accident investiga				Yes 2 □ No				
Š	ter direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		y - At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Numbe. vn, State)	r or Rural I	Route Number,
ב	ital or res af										10
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.	edical	29a. Certifier Check only one) Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and/or	th occurred at the tir nvestigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stat nd due to t	red. he cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Da	ay, Year)
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			30. Name and address of person wh	no completed cause if de	ath (Item 23a) (Type			-1	. 1	0	
			Yadai Chor	don 78	42 60	Print)	K CP	246 100	aleu	Bu	unse,40
	Star Registra		31. Date filed (Month, Day, Year) APR 0 3	JZ. Medistiai	's Signature	and?					
		-		- C. C.	- 1						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 02 Month **Physician** 2008 130001 erson APRIL :01 AM /Medical 4e Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCK GLEN NURSING + REHABILITATION CENTER | 17. Age (In vrs. lest birthdey) | HUnder 1 Year Ballimore If Under 24 Hrs. 7. Age (In yrs, lest birthdey) 8. Date of Birth Birthplece (State or Foreign Country) **Funeral** 1□ M 2Å F Days Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Director 1 Yes 2 No MARIKAND 10e. Street end Number 10f. Zip Code 10a, Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yeer or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Pages 1 and 2 should be filed within 72 hours efter onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel; or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0020 Specify. ģ 3 N Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 HIGRADE 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) 17. Father's Neme (First, Middle, Last) TO NES SEPH 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) BALTIMORE, HD 21229 1200 POTTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department 4 □ Donation 5 □ Other (Specify) 21. Si mature of Funeral Service Licensee FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, resten Due to (br as e consequence of)

Physician/Medical Examiner Medical Certification: To Be Completed by 25. Was cese referred to medical examiner? 27. Menner of Deeth

1 Yes 2 No

5 Pending

1 Netural

2 Accident

3 Suicide

4 - Homicide

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No

3 □ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24a. Was an eutopsy performed?

1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only one) 5 ☐ Residence 6 ☐ Other (Specify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 A Nursing Home 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🖄 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted.

29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) Amotor M Maron

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) NAIAEEM, SOI DOID nin Si

Registrar

32. Registrer's Signature

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I Director: After the din by the funere

To the Hospital c within 24 hours of To the Funeral D

08-02347 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Danielle Johnson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ Month Day March 24, 2008 **Medical Examiner** 2053 hrs ANIEl 10N19ME 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death 1906 Woodbourne Avenue **Baltimore** Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director -38:085 2 X F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County IOc. City, Town or Location 1 X Yes 2 No or 28a-f show penit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than ".... Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code DOULNE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify: BACK 3 Widowed Divorced If Yes, Give Yea Yes 2 No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) SEAMSTRESS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Wood Dourne MOLE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation 2008 4 Donation 5 Other Specify: EWEFER 21 Signature of Funeral Service Licenses 22. Name and Address of Facility 10. Oyett IV. Funeral Service P.A BATTO MO 23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death *:-xaminer a. Heroin Intoxication Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ed for use as the burial - trar Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/9/08 amh X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown this certificate has been signed by the director, page 2 should be detached P.O. 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 examiner? Inpatient 2 DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Yes 2 X No Pending 24 hours after death. To the Funeral Director: Fnd 3/24/08 Fnd 8:45p Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 X Could not be or Town, State) 1906 Woodbourne Ave, Baltimore,MD determined (Specify) Found at home Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

32. Registrar's Signature

ORIGINAL

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 25, 2008

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

APR 0 3 2008

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year **Physician** ackson ayr. 2000 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Verring Parkway Varkuille Baltomore 14nesis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 2,1941 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Days 1 □ M 2 🛚 F Hours Months 217-38-4294 67 Yrs. Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1309 Delvale Avenue 21222 USA 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural" or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X**If Yes, Give
Year or Dates: 2**X** No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White <u>ک</u> 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Government 10 years Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Int: If Item 27 is marked of Abner Haden Jr. Virginia Beatrice White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Haden 1309 Delvale Avenue, Dundalk, Maryland son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April Tate 3, permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility.
Connelly Funeral Home Of Dundalk, P.
7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final march **Physician** Leio myos arcama disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ASLUDE 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an a.116 certificate has briector, page 2 s autopsy performed? 1 Yes 2 ₩No COPO director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To s after dea... ral Director: After ... 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours a To the Funeral L

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 nte 4202 Charles SH Wendy Klorie 31. Date filed (Month, Day, Year) 6 701 11 32/Registrar's Signature

2008

State Registrar

29b. Signature and title of certifier

APR 03

29c. License number 1) 3/295

70wsin

29d. Date signed (Month, Day, Year)

2 1204

4/2/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 6:30A M em March 28 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2310 Cloville Avenue Balto If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min Days Hours 1 □ M 2 F Director 95 212-03-5502 10-8-1912 Md Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Md. 1 XYes 2 No Director Baltimore City 10e. Street and Number 10g. Citizen of What Country? 2310 Cloville Avenue Funeral 21214 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Is marked ot 2 Frank Prucha Mary Svech 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 strent of Health an Anthony Krem1, Jr. 8335 Annalee Avenue Baltimore Md 21237 Important: If item 2, any Injury or are 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer 4-1-2008 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure Physician Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1□Yes 2■No
9□Unknown Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page Hyoutus on
25. Was case referred to medical examiner? 2**V** No 1□ Yes funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[XNo ၉ 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1XX Natural Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 1, 2008

20

State Registrar

APR 0 3 2008

Suite

Good Samaritan

31. Date filed (Month, Day, Year)



ddress of person who completed cause of death (Item 23a) (Type, Print)

511

Sports

Russell Morgan Building

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:05 P.M March Mary Anna Kinder 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5333 Sudley Road Anne Arundel West River If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/21/1922 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗑 F 85 218 14 1322 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **Phow** r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at 1 Tyes 2 No West River Anne Arundel Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20778 U.S.A. 5333 Sudley Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Retail Asst. Manager 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H le marked of William H. Miller Dorothea Haun ပ္ 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Deportment of Heelth at Important: If item 27 le sny injury or other trau 9003. William L. Miller / Cousin 6076 Warm Stone Court Columbia, Maryland 21045 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 04/03/2008 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Cerebrovascular **Physician** discuso /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine attending physician and for use as the buriel-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death signed by the aid be detached for 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24a. Was an autopsy performed?
1 ☐ Yes > No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ospitel or Attending Physhours after death.

Juneral Director: After this ly filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeral C completely filled Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 31, 2008 029193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Killian 3169 Braverton St # 201. Edgewater MD 21037 Stephen 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Certifica	te of Death	Reg	No
	Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	3. Time of Death
/ledica	I Exami		Hadiya Khumalo	Lu ou Tour Lander of De	March 27, 2	4c. County of Death
			4a. Facility Name (if not institution, give street and number) Atlantic General Hospital	4b. City, Town, or Location of De Berlin	eatn	Worcester
F	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign
D	Director	_	690-05-9508 1_M 2_xF 3	Yrs. Months Days Hours I	Oct. 19,	, 2004 Country) NC
	b		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
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;	vith the s 23a		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?		14. Race - American Indian, Black,
	leath v item inst b	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.
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36	uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, th. Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	n/a		n/a
0	led within Hygiene. other tha th Medic	ĕ	17. Father's Name (First, Middle, Last)	18.Mother's N	ame (First, Middle, Ma	
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	s I and 2 s f Health au If item 27 er traums			f Disposition (Name of cemetery, pry or other place)	Date	20c. Location - City or Town, State
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γ i i	permit. Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee	22. Name and Address of Facility W	ylie Funeral	Home, P.A.
			23a. Part I. Enter the disease, or complications that caused the death. Do no	e. Maryland 21217 st. shock, or heart Approximate Interval		
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oʻ	icate be exe physician the burial -	Medical				23d. Date of delivery
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Box 68	ath cer attendi	sicia	4 Pregnant at time of death Yes 2 ✓ No 9 Unknown 9 Unknown	Other (Specify)	**	
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Sor	e law r e has b ge 2 sh	. =			perfor	med? death?
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/ita	ysicial his cer direct	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other	lursing Home 5	Residence 6 Other:
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as so	n: To	27. Manner of Death 28a. Date of Injury 28b. (Month, Day Year)	Time of Injury 28c. Injury at Work? 3 hrs 1 Yes 2 ✓ N	Pedestrian s	now injury occurred struck by auto
ion	tendi death etor: y the f	atio	2 Accident Investigation		1	Street and Number or Rural Route Number, City
ivis	I or Attendate after death	Certification:	3 Suicide 6 Could not be	arm, street, factory, office building, etc.	or Town, S	of Coastal Highway, Ocean City, MD
	Hospital 24 hours a Funeral I	ပိ	4 Homicide	ath occurred at the time, date and place		
	To the H within 24 To the F complete	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	7. W. D.	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
			Don millind mp.	O.C.M.E.		March 28, 2008
2	\circ		30. Name and address of person who completed cause of death (Item 23a)	111 Penn Street, Baltimor	e MD 21201	
6	人		Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature		U, IVID & 12U I	
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Cynthia Z. Khumal		- For State	St	ate of	Maryland			of Health of Death		ntai Hy		20	08	10731	
· ·	R	egistrar . Decedent's Name	o /Firet Midd	le Last)			runcate	Of Death			Reg 2. Date of Death	J. 140.		Time of Death	
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	4	la. Facility Name (i Peninsula R				г)			4b. City, Town, or Location of Death Salisbury 4c. County of Death WicDmicD						
Funeral		5. Social Security N	lumber	6. Sex	7. A	ge (In yrs.	last birthday	/) If Under	1 Year If Un	der 24Hrs.	8. Date of Birth	(MM/DD/YYYY)		lace (State or South	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It liet 27; marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu 3005 Roman		t A	pt. A			10f. Zip	21209		Į.	g. Citizen of Wh	USA-		
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Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		1 X Burial 2		n 3	Removal from	State		or other place)	11	01.10	5/2008	Dumbon I	Z	u Natal;SA	
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	+	23a. Part I. Enter th	he disease of	complic	ations that cause	ed the dea	th. Do not er							Approximate Interval	
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	Medical (29a. Certifier (Check only one) 2	5	aminer:	On the basis of e	examination	edge, death n and/or inve	occurred at the estigation, in my	e time, date and y opinion, death	d place, and h occurred	d due to the cau at the time, date	se(s) and manne and place, and	er as state due to the	d. e cause(s)	
To with To com		29b. Signature and			and manner state	ed.		29	c. License num	ber		29d. Date sig	ned (Mor.	th, Day, Year)	
		Down	nu) inc	L,MD).			O.C.M.E.			March 28,	2008		
7	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
<u></u>	State 31, Date filed (Mooth-Day, Year) 32. Registrar's Signature														
	State 31. Date filed (Mogth, Day, Year) 32. Registrar's Signature egistrar														

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year (EWIS LINDA 7:00 AM 31,2008 MARCH 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NA HUSPICE RICHEY BALTIMORE JOSEPH If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours 1 □ M 2 🔀 F 59 JANUARY 30, 1949 212-48-0239 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number LANVALE ST., APT. #312 1300 E. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED COSMETOLOGIST 10TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUBY TAYLOR WILLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER) 4988 BRIGHTLEAF CT, BALTIMORE, MD 21237 DAVETTE GRAY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 04-01-2008 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MULLIANS 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) the Cancer Due to (or as a consequen) of) > 1 year Sequentially list conditions, if any, leading to immediate cause. Each underly of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 26. Place of Death (Check only one) J. Richey Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient HOSPICE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

(Check only one)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certific

Physician

March 31,

21287

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) N. Wolfe Street DONG NGUYEN, MD 600

State Registrar

Physician

/Medical

Examiner

Funeral

Director

rral", or items 23a or 28a-f show Examiner must be notified at

"natural"

other traumatic event, the Medical

marked other than

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Physician

/Medical

Examiner

the attending physician

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filled in by the fureral director, page 2 should

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Director:

within 24 hours a To the Funeral C

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Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification: To

31. Date filed (Month, Day, Year)

32. Registrar's Signature

amend item 4a per doc 10e per fh 8878 4-10-08 vt. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JAMES H. LIGHTFOOT, SR 10:15 30 2008 MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE COURTLAND WOODS CIRCLE PIKESVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days **№** M 2 F 80 5/8/1927 Director 226-20-4395 VIRGINIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at XIXYes 2 □ No Director BALTIMORE PIKESVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be USA 1 COURTLAND WOODS CIRCLE 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mertal Hyglene.
Int: If Item 27 Is marked other than "natural", or itee iny or other traumafic event, the Medical Examinea iny or other traumafic event, the Medical Examinea. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION MAINTENANCE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLOYD LIGHTFOOT SARAH HOLLOWAY ပ 19a. Informant's Name/Relationship (Type. PrinaUGHTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 COURTLAND WOODS CIRCLE, PIKESVILLE, MD CHARLOTTE LIGHTFOOT-GARRISON 2 20b. Place of Disposition (Name of MD CENETERY Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ortant: If I CROWNSVILLE, MD 4 □ Donation 5 □ Other (Specify) CROWNSVILLE VA 4/8/2008 22. Name and Address of Facility 21. Signature of Funeral Service Licens 10220 GUILFORD RD HOWELL FUNERAL HOME JESSUP, MD 20794 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Approximate Interval Between Onset and Death he failure. iat Cause (Final 41/24845 **Physician** METOUSTATIL GASTION-INVESTINA diseal r condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed nding physician and use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \subseteq Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5X Residence 6 ☐Other (Specify) ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D38509 ichulas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelus IN ROUTRE 11065 Li Atle PATELISENT Parkus Columbia Mary kun 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 3 2008

Jules

32. Registrar's Signature

08-02393	
Joel Long	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

el Long			ate of Maryla	and / Dep	artment of	Health and	d Mental	Hygiene	Reg. N	200	8	0734	
	1- For State Certificate of Death Registrar Physician 1. Decedent's Name (First, Middle,Last)										3. Time of		
Physician/ ledical Examine		Joel Long	08	1425	hrs								
¥	4a	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
	L	2301 Maryland Avenu		[7 A (la	loot hirthday/	If Under 1 Yea	r If Under 2	4Hrs. 8. Date	of Birth (M	M/DD/YYYY) 9. B	irthplace (St	ate or Foreign	
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tified the		2301 Maryland	Avenue			21218		0 / 0 t . V		U.S.A. 14. Race - American Indian, Black,			
r death with or items 23	1	Marital Status Never Married 2 M	12. Was De	ecedent Ever in Forces?	U.S. 13. Wa	as Decedent of Hi es, specify Cuba	ispanic Origin in, Mexican, P	uerto Rican, etc	:.)	White, etc.			
or ite	5 3		1 Yes		1	Yes 2X N	o specify:			Specify: W	Vhite		
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5-0 lled will Hygie		7. Father's Name (First, Middle	, Last)					ra Ande		do ,, do ,,,,,,,,,			
	u	Everett Long 9a. Informant's Name/Relation	ship (Type Print)		19b. Mailir	g Address (Str	eet and Numb	er or Rural Rou	te Numbe	r, City or Town, St	ate, Zip Cod	e)	
MD 2 d 2 shoul lith and M m 27 is m aumatic	- 1	Barbara Long	(MOther)		606	Churchi	11 Rd	Bel Air	, MD	21014			
and 2 fealth	2	Oa. Method of Disposition			b. Place of Dispo crematory or o	sition (Name of o	emetery,	Date	2	20c. Location - City	or lown, St	ate	
JOFE ages 1 nt of H nt: If i	- 1	Burial 2 X Crematic		from State	ayview (у	03-31-2	800	Baltimo	re, MD		
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and M Important: If Item 27 is in injury or other traumore.	1	Signature of Funeral Service	e Licensee	io	22.	Name and Addre	ess of Facility	Schimun	ek F	uneral Ho	ome of	Bel Ai	
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Physician	- 3	23a. Part I. Enter the disease, of failure. List only one caus	e on each line.								Betwe	een Onset and Death	
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ivisior I or Attend after death Director:	fica	3 Suicide 6 X C	Could not be 28e.	Place of Injury -	At home, farm, s	treet, factory, off	ice building, e		Town S	street and Number			
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							e(s) and manner a and place, and du	e to the caus	se(s)				
The state of the past of the p							29d. Date signed	d (Month, Da	ay, Year)				
29b. Signature and title of certified					O.C.M.E. March 27, 2008								
		30. Name and address of per	y who completer	cause of death	(Item 23a)								
		Jack Titus MD.	Seputy Chief M	ledical Exan	niner 111 i	Penn Street,	Baltimore,	MD 21201					
S	tate	31. Date filed (Month, Payr)	a7008 1	32. Registrar's S	ignature	Will service							
Regis	trar	WILLAS	2000	14.1									

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		1- For State Registrar				Certific	cate of	Death				Reg	No.			
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2		436 Hillviev		-	and number)				inthicum Heights				Anne Arundel			
Funeral Director		5. Social Security I 217-08-5		6. Sex		(In yrs. last bi		If Under 1 Months		nder 24H ours N	Ain.	8. Date of Birth (MM/DD/YYYY) 9 Fo				e or
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h with tems 23a	Funeral	11. Marital Status		12. W	as Decedent E	er in U.S.		s Decedent o es, specify C				pecify Yes or No- 14. Race - American Indian, Bla				Black,
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5-0036 led within 72 h Hygiene. other than "r the Medical E	Completed	Elementary/Sec	ondary (0-12)	Col	lege (1-4 or 5 5+	+)		otomist			000)		Holy Cro	ss Ho	ospital	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Son	17. Father's Name	(First, Middle	e, Last)					18.Mot	her's Na	me (First	t, Middle, Ma	aiden Surname			
21215-(21215-(ould be filed a Mental Hygi marked oth	Be			ac Linto								Gloria				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewill in 12 hours after death with the Maryland Importment. If item 21 is marked other than "natural", or items 23a or 28a-18he injury or other traumatic event, the Medical Examiner must be notified at once	Ţ	19a. Informant's N Gloria 1			nt)	1	-						er, City or Tow rnie, MD			
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BOX 687 he death certific the attending pred for use as the	Physiciar	past 12 month	s? No 9 ✔ Ur	4	Pregnant at t			ner (Specify)								
D. BC t the dea by the a	Phy	Part II. Other sign		9_	Unknown uting to death	but not result	ing in the u	nderlving ca	use alven i	n Part I.		23e. Did tob	acco use conti	ibute to	the cause o	f death?
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BCO ne law te has ge 2 s	щ			•				-			-	perform	ned?	death?		No
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VITAI KEC tysician: The this certificate director, page	o Be	examiner?	2 No	Hospital:	1 Inpatier	nt 2 ER/	Outpatient	3 DOA	Other	Nu	rsing Ho	me 5 F	Residence 6	✓ Other	: Scene	
Of ing Ph After t uneral	n: T	27. Manner of Dea	ith	288	a. Date of Injui (Month, Day,Ye	ry 28t sar)	. Time of I		. Injury at V		28d.	Describe ho	ow injury occur	red		
Pending Investigation Fnd 12:30p 1 Yes 2 No Unk																
See Place of Injury - At home, farm, street, far								fice building	g, etc.		or Town, Sta	reet and Numb				
Hospital 24 hours Funeral tely fillec	ပ	4 Homicide 29a. Certifier	1	Physician: To					an data an	d place of			iew Rd.Ap			icum He
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2	Medical Ex	aminer: On the	basis of exan	nination and/o	r investigat	ion, in my op	inion, deat	occurre	ed at the	time, date a	nd place, and	due to th	e cause(s)	
Te wir	and manner stated. 29c. License number 29d. Date								29d. Date sign	ned (Mo	nth, Day, Ye	ar)				
		70	Join Jeg mo										April 1, 20	80		
0		30. Namé and add Tasha Gree				eath (Item 23a Il Examine		Penn Stre	eet, Balti	more,	MD 21	201				
	tate	31. Date filed (Mor	oth, Day, Year,	2008	32: Registrar	's Signature	Joseph	-								
Regis	Heli	H	11 00	2000	M. Charles Backer	000	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 28 2000 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number If Under 9. Birthplace (St Country) 6. Sex Ade (In yrs. last birthday) **Funeral** Vear Min. Months Days 1 □ M 2 □X 72 BALTIMORE 12/16/1935 217-34-8666 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director N/A BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA AVE 21207 3616 GWYNN OAK Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify Specify: BLACK 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12 CLERICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET BOOTHE ORVILLE CLINTON RANDALL ပ or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other trauones. GWYNN OAK AVE, BALTIMORE, MD 21207 / HUSBAND RODELL A. MILES 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State 4/2/2008 BALTIMORE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4600LIBERTYHROGBTS BALTIMORE, MD21207 HOWELL FUNERAL HOME 23a. Part. Enter the glsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line.

Immedia. Lause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Due to (or as a conseque of of): /Medical Examiner Sequentially list conditions, if any, leading to influediato cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 【X No 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 □ No 2 No 1 Tyes Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 27 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Medical Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VZZ

32. Registrar's Signature

at 11:00pm 3/29/08 P.O. Records, ROPIEN Vital 0 Division HARRISON

filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at Maryland 21215-0036 traumatic event, the Medical marked other Pages 1 and 2 should be fill timent of Health and Mental Hiant: If item 27 Is marked out permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Baltimore, Physician /Medical Examiner burial-trar physician the attending pl for use as t the funeral director, Certification: To Hospital or Attending 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Spe~ify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 | Homicide / filled To the Hospital within 24 hours at To the Funeral Completely filled 10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Teelll W npleted cause of death (Item 23a) (Type, Print) 6301 N Charles Street Baltimore, MD 21212 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:37p. Sterling Middleton 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours **X**□ M 2□ F 213-26-8881 Yrs. Director 78 06 29 08 MD Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at Director MD NA Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 4304 Elderon Ave 21215 Funeral death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. þ 3√2 Widowed 4 □ Divorced Specify: Black "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Balto. City Bureau Elementary/Secondary (0-12) filed withir Hygiene. marked other than College (1-4or 5+) 12th grade Supervisor Water Supply Maryland wuld be filt, and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Middleton Robena Boone Gross ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Ann Jubilee of Health item 27 4304 Elderon Ave, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of I Important: If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest vet 4/7/08 Owings Mills, Md 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final To mon **Physician** Neuroendocine months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran 68760, Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform of Vital 1 □Yes 2 2000 1 TYes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) WDS PLU 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

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Charles ST TOWSON MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** 03.20AM Joseph Barry Munroe MAR 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BAL TIMORE HOSPI AGNES N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ★M 2 □ F 490-24-4340 82 25, Feb. 1926 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 715 Maiden Choice Lane PV 4901 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Consulting al Hygiene. College (1-4or 5+) Accountant Engineers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F Joseph Martin Munroe Eleanor Barnhart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ernestine Munroe - Wife 715 Maiden Choice Ln PV 401, Catonville, MD 21228 of Health Date 20c. Location - City or Town, State Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Department of I Important: If ite any Injury or ot West Arundel 4-2-2008 Odenton, MD 5 ☐ Other (Specify) Crematory 22. Name and Ad ress of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END STAGE Physician LUNG DISEASE UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CONCESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transi The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe Yes 2 To the Hospital or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 De Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: /
filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific MAR 31 2008

MUNIROE, JOSEPH

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



CHANDRA BOMMAMD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:26 P M Apri1 Williams 2008 William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Medical Center Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Min. Months Days Hours 1 XM 2 □ F Jan 28, 1914 Pennsylvania Director 159-01-2409 94 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Gambrills Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a 21054 2610 Chapel Lake Drive, #406 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 ò þ Specify: 3 Widowed 4 Divorced 'natural", Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Deluxe Cab Company other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental item 27 is marked of S. M. Miles Williams Harry Cora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lilian Miles Green/daughter 2610 Chapel Lake Drive #406 Gambrills, MD 21054 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State West Arundel Crematory 4/3/2008 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licens uanta R Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final days 'heumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? I Director: After the in by the funera Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 46052 6+1 gause of death (Item 23a) (Type, Print) Purkway announces, MD 30. Name and address of person f person who completed caus 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:30 A.M March 29 2008 Robert C. Moyers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 215 Southerly Road Baltimore Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08/18/1938 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Country) Virginia 1 X M 2 □ F 69 Director 223 42 1856 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23s or 28s-f ahow 10c. City. Town or Location 10d. Inside City Limits 10b. County ir than "natural", or Itams 23c or 28a-f ahow 1 ☐ Yes 2 X No Director Baltimore Baltimore Marvland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3014 Delaware Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ Nd 955— If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communication Electronic Tech. years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Moyers Goldie Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is Baltimore, Maryland 21227 3014 Delaware Avenue Mary Moyer / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 04/02/2008 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 14001 Kitchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** pancreatic a Metastatic cancer N 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trag Due to (or as a consequence of): ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 0 After this funeral of 27. Manney of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Diractor: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MIS 00058893 31 Warch 2008

Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, $oldsymbol{arkappa}$ within 24 hours at To the Funaral C

Baltimore, Maryland 21215-0036

30+1 State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 0

5.

Neve



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Eastern

Arence

Setternore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State		State of Ma	ıryland		rtment of F tificate of I			gienę Reg. No.	2008	10742		
1				Registrar 1. Decedent's Name	e (First, Middle, Las	it)					2. Date of Dea			3. Time of Death		
v-s		Physicia /Medica		HELEN NOWA	KOWSKI						MAR	31	2008	0345 A M		
	a Marie	Examine			Name (If not institution, give street and number) 4b. City, Town, or Location of Death									4c. County of Death		
	- /			STELLA MAR 5. Social Security N									BALT I MOF	place (State or Foreign		
		Funeral Director		212.09.917	72 1	□ M 2 K XF	93	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da NOV 18	y, Year) , 191 ¹	Cot	PA		
		land ow	ł	Usual Residence of 10a. State	10b. County		10c. City,	Town or Loc	eation					10d. Inside City Limits		
		Mary I-f sh	ţċ	MD	ANNE ARI	JNDEL	5	SEVERN						1 □Yes 2 □ No		
		or 282	Director	10e. Street and Nur	mber				10f. Zip Code			10g. Citi	zen of What Cou	intry?		
		th wil		7927 CLAR	STATION RE				21144				SA			
، يا	ယ	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Exam nor mast be notified at	Funeral	 Marital Status Never Marri 	ied 2□ Married	12. Was Decedent E Armed Forces? 1 Tyes 2XXN	Ever in U.S Io	- 1		ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	, etc.		
a.m	5-0036	"natural", or	d by	3 Widowed		If Yes, Give Year or Dates:			□Yes 2☐No			165 K	Specify: WH			
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2008	aryland	should be and Mental is marked of aumatic eve	၉	JULIAN LAZ			_			MARIA RZI		0/4	Town Chata 3	in Code)		
	ă Z	nd 2 sh alth and 27 Is m er traum			ame/Relationship <i>(</i> S NOWAKOWSK)NI		•	and Number or Ru CR., COLUN			ir 10wii, State, 2	ip Code)		
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MAJ	Balt	permit. Page Department of Important; If any injury or once.		21. Signatur	GREGORY	1NK M01148				ss of Facility HOME,P.A Y.S.,GLEI		MD	21061			
				23a. Part 1. Enter t		blications that caused one cause on each lin	the death.		er the mode of dyir	ng, such as cardiac	or respiratory a			Approximate Interval Between Onset and Death		
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	ď	/Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of):								
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	68760,	icate be executed physician and the burial-transit	edical E	resulting in death)	Last	Due to (or as	a consequ	ence oi).								
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1.1	O. Box	Attending Physiclan: The law requires that the death certificate be executed roteath. The death crossed with the certificate has been signed by the attending physician and extor; the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 [Ectopic pregnand Other (specify) _	су			23d. Date of del Month	ivery Day Year		
NOWAKOWSKI	ري ح.	res that the de signed by the a be detached i	by Ph	Part II. Other signi	ficant conditions	contributing to death be	ut not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco		the cause of death?		
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HEI	-	ysicla is cer direct	To Be	examiner? 1 ☐ Yes 2 🕱		Hospital:	ent 2 🗆 I	ER/Outpatie	nt 3 DOA Oth	or:	-		6 X ☐Other (Spe	cify) HOSPICE		
	n of	ding Physiclan; The h. h. After this certificate h. funeral director, page		27. Manner of Dea	5 Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	Woi		28d. Describe	how inju	ry occurred			
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		To the Hospital or within 24 hours aft To the Funeral Di completely filled in	Medical (29a. Certifier (Check only опе)	1X Certifying P 2 Medical Exa	nvsician: To the best miner: On the basis o and manner st	of examinat	wledge, deat tion and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(: , date an	s) and manner a d place, and due	s stated. e to the cause(s)		
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DHMH 17 Rev 1/2001

3:45 a.m.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** 8:00 P M March 30, Pollnow Cynthia Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F 1942 Wisconsin 387-40-4622 21 Director 66 Jan. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 United States Funeral 5203 Elsmere Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or the any Injury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: <u>ک</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Disaster Mitigation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Flemming Edward Hruz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13811 Last Line Lane, Fredericksburg, Virginia 22407 D. Pollnow / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 1 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium Inc. 2008 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01193 BOO W. Montgomery Ave., Rockville, Maryland 20850 br. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ovarian Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6 MOther (Specify) Hospice Certification: To s after death.

I Director: After this od in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. within 24 hours a To the Funeral I completely filled

State

Registrar

and address of person who completed cause of death (Item 23a) (Type, Print) G∉nevieve Wroblewski, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

M.D. 1355 Piccard Drive, Rockville, Maryland 20850 32. Registrar's Signature

DHMH 17 Rev 1/200

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

March 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** meta 4c. County of Death DINO /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Oak Crest Village Parkville If Under 24 Hrs. 8. Date of Birth (Month, Day Year) March 7, 1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 80 Yrs. **Funeral** Months Days Hours Min. Mary Land 1□M 2XF Director 212-26-9523 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 14 Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r Apt 2003 21234 8820 Walther Blvd. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) 12 <u>Administrative Secretary</u> Library permit. Pages 1 and 2 should be fileo. Deparment of Health and Mental Hygin Important: If item 27 is marked any injury or other **-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy O. Rule Emma Peppler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2431 W. Carmen Ave. John Pipino, son Chicago, IL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 3-31-08 Odenton, MD 21. Signature of Furreral Service Licensee ²² Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseasa or condition resulting in death) Meumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a conse Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No icate has to page 2 sl autopsy performed certificate 2 No Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ M 1 Inpatient 2 ER/Outpatient 3 DOA P Division or After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation within 24 hours after usure for the Funeral Director: After Funeral Director: After the filled in by the fill 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 28

Registrar

31. Date filed (Month, Dav. Year) 0 3 2008

30 Name and address of person who completed cause

8800 w 32. Registrar's Signature

of death (Item 23a) (Type, Print)

2

TPINO

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death April 2, 2008 Year 12:08 A M Sophia Pennington 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis Eldercare - Heritage Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 5,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 💢 F Maryland 218-05-5138 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11 Maryland Avenue 21222 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 7 years Bethlehem Steel <u>Time Keeper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alec Dorowitch Anna Basacinkia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Zang 1108 Oaktree Drive, Havre De Grace, Maryland 21078 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April ate 3. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 2008 4 Donation 5 Dother (Specify) Baltimore City, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Int. Enter the disea of or complications that caused the de ab. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ERATIC CARDIO VASCULAR DISTAGE disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury EMENTIA that initiated events resulting in death) Last Due to (or as a consequence of) PRESSION IE EEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? itions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♣ No 24a. Was an autopsy 26. Place of Death (Check only one)

Physician /Medical Examiner

and

physician

The law requires that the death certificate be executed

Hospital or Attending Physician:

the

within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he moritien at

Baltimore, Maryland 21215-0036

Examine burial-transit by Physician/Medical should be detached for Completed Certification: To Be filled in by

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No
Part II. Other significant cond

25. Was case referre examiner?	ed to medical
1 ☐ Yes 2☐	М
27. Mann of Death	
n Matural	5 Pending

investigation 2 Accident 6 Could not be determined 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 3∏ DOA 28c. Injury at Work?

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my calcular death. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 03 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔈 🗍 🗍 🧍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 21, Day 2008 Physician 5:30 P M Alice Tamson Ricucci /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Collingswood Nursing Home If Under 1 Year If Under 1 Year Hours 8. Date of Birth (Month, Day, You Oct. 30, 9. Birthplace (State or Foreign Country) 1924 Washington, DC Under 24 Hrs 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months 1 □ M 2 🗓 F 83 Director 578-24-1966 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Whysiene "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director North Potomac Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20878 12500 Split Creek Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 Is marked other the any Injury or other traumatic event, the once. Day Care 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Burroughs Harry Jacobs ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12500 Split Creek Court, North Potomac, MD 20878 Brenda K. Kehr/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial 20c. Location - City or Town, State Apri $\overset{\mathsf{Date}}{1}$ 2, 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 2008 Rockville, MD 4 Donation 5 Other (Specify) Park 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Gangrene /Medical Due to (or as a consequence of): Examiner Osteomyelitis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Peripheral Vascular Disease and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No detached 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 s autopsy 1 ☐ Yes 2 ☐ No certificate 1∐ Yes 2**X** No Physiclan: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) Injury Hospital or Attending 1 🛚 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 31, 2008 H0051280 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person Anushiravan Dadgar, D.O. 9715 Medical Center Dr., #201, Rockville, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 Fred Richter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne A 6len Buinie Baltimore Washington Medical Center Birthplace (State or Foreign Country) If Under 1 Year I f Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F 69 May 6, 578-48-9535 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10b. County 1 ☐ Yes 2X No MD Funeral Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 514 Marion Road 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Wholesale Appliances 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Fred Richter Agnes Guckion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 514 Marion Road Glen Burnie, MD 21061 Mrs. Lucy Richter/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 2008 Department of Important: If it any injury or c W Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Glen Haven Mem. Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funetal Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 MOIYII 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 1 weeks ano xic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, pe 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Wes in March

State Registrar Balti more

31. Date filed (Month, Day, Year) APR 0 3 2008

DHMH 17 Rev 1/2001

ORIGINAL

Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

washington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2004 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, dive street and number, 4b. City, Town, or Location of Death **Examiner** BALTIMORECITI ENERA BALTIMORE MARYLAND HOST 17742 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Year Months Davs Hours Min. 1 □ M 275 13-76-2137 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 Yes 2 □ No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ed other than "natural" or items 23a or event, the Medical Examiner must be r Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RIVATE 2 HTGRADE 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be è. and Mental P Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TUNISIA Department of Health Important: If item 27 any injury or other trong once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses MD21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner be executed 2171010 physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown signed t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate has autopsy performe 25. Was case referred to medical examiner? 26. Place of Death Check onl o e funeral director Be 2 No REFISED Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 BR/Outpatient 3 DOA ۵ 1 ☐ Yes 1 Inpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's Signature 29c. License number

WIDEN

29d. Date signed (Month, Day, Year)

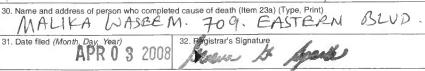
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Evelyn B. Seeger /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bultimore Hospital oseda Year If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 1 F 94 12-27-1913 Chicago. Director 174-10-7859 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2 No Director Md. Nottingham, Md 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 6A Haspert Road 21236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ PEGEL LVELYD Itimore, Maryland 21215-003 3. Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Homemaker</u> Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Iola Warner Frank V. Rickey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10027 Magledt Rd. Parkville, Md. 21234 James G. Seeger Son Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Northampton Memorial 3-27-2008 Pa. Easton, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Relair Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 2 No 3 Probably 4 ☑ Inknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2 1 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2X☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03-23-2008 -M.D.

0 State Registrar

31. Date filed (Month, Day, Year) APR 0 3



MD-21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 2. Date of Deat 03/26/2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 3:46 PM Betty Lou Slembecker Touch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Hosptial Bel Air
If Under 1 Year If Under 24 Hrs. Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F Maryland 213-34-1657 71 11-10-1936 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and it I flem 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland Harford FA11ston 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1800 Watervale Rd 21047 U.S.A. Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own HOme 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Nemsick Alverta Lanham 2 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George L. Slembecker Jr 1800 Watervale Rd Fallston, MD 21047 Baltimore! 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Bayview Crematory 04-02-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardias 12 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 12 chemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated and the cause of the caus Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 1 Watural 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 777 March 26, 2008 D0053568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar APR 0 3 2008

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State of Maryland	d / Department of Health and	l Mental Hygiene 🗸 🕒

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ,30PM 29.2008 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Ceno Cherrywood 12020 Reisterston M.D. 21136 Baltimore If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Social Security Number 2 15 - 22 - 486 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 1 F Yrs. 87 29, 1921 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Lutherville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Iteme 23a 1422 Bellona Avenue 21093 Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2√2 No Specify: Specify: USA 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Private family College (1-4or 5+) 7th grade Domestic or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental P Clement Smith Ella Baylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any Injury or other trau 2952 Beaverwood Lane Silver Spring, Maryland 20906 James C. Smith/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 4/9/08 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman—Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 21. Signature of Funeral Service Licens 23a. Pant. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each in the Interval Between Ofset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ysicien and e burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed be del Part II. Other significant condition ntributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Natural 5 Pending м 1 Yes 2 No death. investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of titier 30. Name and address of person 31. Date filed (Month, Day, Year) 32 Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2040 M Barbara Lorraine Stewart 2008 31 MAPCH /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days Hours 1 □ M 214-44-6940 Director 1 - 13 - 1946MD Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 TT S Α 28 Orion Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 ☐ Widowed 4 🔀 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Dep College (1-4or 5+) 2 years Elementary/Secondary (0-12) 12th grade Office Public Works Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernita Merritt THOMAS ANDREW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Road Suitland, permit. Pages 1 and Department of Health Important: If Item 27 I any injury or other tra 4404 Rena MD 20746 Bronte Stewart -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-5-2008 MD King Memorial Pk Randallstown, 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East lade won 21202 Balto,MD <u> 1101 E. North Avenue</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ulmonar /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day for 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by sign be (2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours a er dea h. To the Funeral Lirector 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier Physician march 31, 2008 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, Baltimore 400, MD union memorial Helena 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR V3

Registrar

Charles Sand

08-02400 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Norman Smith, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day March 26, 2008 Medical Examiner 1654 hrs Norman I.a

4a. Facility Name (if not institution, give street and number Smith Lance 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore City** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) TN Months Davs Hours Director 09 45 12 62 212-84-5957 1 X M 2 F Usual Residence of Decedent any 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1X X Yes 2 No or 28a-f show items 23a or 28a-f shoust be notified at once. NA Baltimore MD death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Olympia Ave 21215 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Examiner must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes Yes, Give Y than "natural", or Widowed , Give Year Black Divorced 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: If item 27 is marked other than "na minury or other traumatic event, the Medical Ex Elementary/Secondary (0-12) 72.1 College (1-4 or 5+) 12th grade 3yrs Student Univ, of Baltimore 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Norman E. Smith Norma Morrow 19a. Informant's Name/Relationship (Type, Print) Parents
Norman & Norman Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3503 Olympia Ave, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore. Date Burial 2 Cremation 3 Removal from State crematory or other place) 4/2/08 Fern Oaks Griffith, Donation 5 Other Specify: 21 Signature of Funeral Service License 22. Name and Address of Facility
March F/H West umu 4300 Wabash Ave, Baltimore, 21215 Md Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician led for use as the burial Item//19a,perFH,C878,4/3/08,WS Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes After 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: Mar 26, 2008 Subject shot Natural 1607 hrs Yes 2 ✔ No Director: d in by the f Pending within 24 hours after death. 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 3503 Olympia Avenue, Bałtimore, MD determined 4 V Homicide (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** To the l 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCME 2006

31. Date filed (Month, Day, Year) 2008 Registrar DENVIR 17 Rev 1/2001

State

29b. Signature and title of certifier

Jon my

Donna M. Vincenti, MD

32, Registrar's Signature

Assistant Medical Examiner

WELLES

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 27, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month 04 ÕΊ 2008 Izmathulla 15:58 <u>Shamohamed</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 422 York Road Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1**X** M 2 ☐ F Director 068-90-9055 55 09 India Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 □Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 422 York Road 21204 India 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 21 No Specify. δ Specify: 3 Widowed 4 Divorced Asian Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Towson Food Corner na Manager 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ဂ္ဂ S Ali Raza Hussain Fahmunissa Hussain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Muhammad Awais Rana-Friend 804 5th Ave, Halethorpe, Md 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mahvilli, Gravevard 4/7/08 Banglore, India 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Inompson 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diseaso **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 2 No 1 ☐ Yes 2 X No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¥Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) ture and title of certifier

State Registrar

3

Name and address of person

Trim

of death (Item 23a) (Type, Print)

e

32/Registrar's Signature

29c. License number

ble Hill CT. Lytherville, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1, 2008 **Physician** 12:40P M Donald Herbert Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2147 Streamway Court Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 1955 Maryland Jun 19, Director 213-64-6889 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XNo Directo CA San Diego <u>San Diego</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 92108 USA 6304 Rancho Mission Road #184 Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
ant: If Hean 27 Is marked other than "natural", or Items 233 unit. If them 27 Is marked other than "natural", or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. I XYes 2 □ No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black ģ 1980 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Information Technology Elementary/Secondary (0-12) College (1-4or 5+) 5+ Information Technology Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Evelyn Wigfall Rufus Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2147 Streamway Court Baltimore, MD 21207 Vida D. Jennings/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or Chesapeake Crematory 04/03/08 Beltsville, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Clarksville. M01251 Beverly L. Heckrotte, P.A. MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SMALL NON **Physician** Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): as the burialphysiciar Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? signed by the at d be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t irector, page 2 s autopsy perform 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Sisters Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: within 24 hours a To the Funeral I completely the 2

State Registrar 31. Date filed (Month, Day, APR 0

29b. Signature and title of certifier



2008

and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Day **Physician** 31, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days September 12, 1914 Mary Land 1 □ M 2 💢 F 215-07-9760 93 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 220. any injury or other traumatic event. The Maryland ones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland| Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 334 Wye Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Stedolny Jacob Semenkow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1764 Brookview Road, Dundalk, Maryland Lynn Sprouse Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 2. 1 ☐ Burial 2X1 Cremation 3 ☐ Removal from State Bayview Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Myre 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the dise se or complications that caused the di ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Physician HYPERCARBIA 12 Hars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPOXIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit PULMONARY resulting in death) Last Physician/Medical ONG. ESTIVE HEART IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? res 2 14 No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in

Division or Vital Records, P.O. Box 68760.

State Registrar 29a. Certifier

29b. Signature and title of certifier

Medical

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Michelle Zekuska, MD

Michelle Zikusaka

JOHNS HOPKINS BAYVIEW 4940 EASTERN AVE BALTIMOIEE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) March 26, 2008 **Physician** 1:30p M Herbert Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 910 Minna Avenue Prince Georges Capitol Heights If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WASHINGTON, DC 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1**X**M 2□ F 579-64-5216 Director 59 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;" or items 23a or 28a-f show any Injury or rother traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director P.G. MD Capitol Heights 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 910 Minna Avenue 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) D.C. Gov't. Social Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herbert Lee Smith Dowling Jessie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LeAnthony Smith - Son 2554 Pomroy Rd., SE Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Opermation 4 Donation 5 Other Spe Glenwood Cemetery 04-05-08 Washington, DC 21. Signature of The al Service 22. Name and Address of Facility Taylors Funeral Home 1722 North Capitol St NW Wash DC 20002 flications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final **Physician** Coronory Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-tran Due to (or as e consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ End Stage Renal Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2 XNo Hypertension 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation injury 1 Natural 1 Yes 2 No M 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, $ec{oldsymbol{arphi}}$ e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica filled in by the funeral director.

> 10 State Registrar

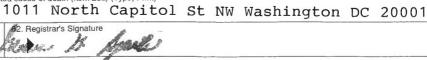
Medical

31. Date filed (Month, Day, Year 2 0

Gaybso,

MD

30. Name and address of berson who Edsel Gavoso.



completed cause of death (Item 23a) (Type, Print)

and manner stated.

29a. Certifier

29b. Signature and title o

29c. License number

mo 2/240

29d. Date signed (Month, Day, Year)

April 1, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician George Smith 9:00 a M March 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3212 Dunwood Ridge Terrace Prince Georges Bowie If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F Birthplace (State or Foreign Country) **Funeral** Months Director 03-02-1925 109-18-4326 83 Georgia Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10b. County 10d. Inside City Limits "naturel", or iteme 23s or 28e-f shov alical Exercitive must be notified at 1X Yes 2 No Md. P.G. Bowie Direct 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 3212 Dunwood Ridge Terrace U.S.A. 20721 death 12. Was Decedent Ever in U.S. Amed Forces?

12. Yes 2 1 94 3 - 1794, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Defense other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th Security Officer Intelligence Serv. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) nd 2 should be fi th and Mental H 27 is marked of Smith George Mary Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 3212 DUNWOOQ RIGGE TETTACE, nt of Health a : If item 27 is or other tree Vioette Cook - Daughter Bowie, Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1X Burial 20 Cremation /3 □Removal from State permit. Page Department o Importent: If any injury or 04-07-08 Md Veterans Cem. Cheltenham, Md. 4 Donation 5 Dother Apacify) 22. Name and Address of Facility Taylors Funeral Home 1722 North Capitol St NW Wash DC 20002 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Electrolyte Abnormality /Medical Due to (or as a consequence of): Examiner Chronic Renal Failure if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and the burial-transit Cancer of the Colon Due to (or as a consequence of): Completed by Physician/Medical Hypertension and Diabetes Mellitus as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy detached for Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 1 ☐ Yes 2**X** X00 3 Probably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has autopsy performed?

1 Yes 2X No certificate Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No s after death 2 Accident mpletely filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 0 To the Hospitel o within 24 hours aft To the Funerel Di 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

X

State Registrar

Allison R Edwards, 31. Date filed (Month, Day, Year) APR 02

MD.

30. Na e and address of person who complet d cause of death (Item 23a) (Type, Print)

14300 Gallant Fox Lane #226 Bowie Md 20715 32 Registrar's Signature A States

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore.

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Records,

Division of Vital

AMPD0032051

March 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	dical niner		4b. City, Town, or Location of Death	7.174	4c. County of Death
	n-ma	Shady Grove Adventist Hospital	Rockville		Montgomery
Funer Directo	_	5. Social Security Number 5. Social Security Number 6. Sex 1 ☒ M 2 ☐ F 89 YI	Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 17, 1	9. Birthplace (State or Foreign Country) Virginia
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		10d. Inside City Limits
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h the r 28a	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
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I'Ce, IMATYIANG 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Funeral		 Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto □ Yes 2 ☒ No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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or Health item 27			Robin Hood Hill, S		Corest, MD 21405
		Examinate 2 Cremation 3 Hemoval from State	crematory or other place)		•
Baltimore, permit. Pages 1 at Department of Hea Important; If item any injury or othe	ei l	4 □ Donation 5 □ Other (Specify) Arlington 21. Signature of Funeral Service License	National Cemetery June 4		
Dep Dep and	on one	M00896	Robert A. Pumphrey Funera 7557 Wisconsin Ave.	, Bethesd	la, Maryland 20814
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or hear failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
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	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outr		h <i>(Check only one)</i> me 5 ☐ Residen	ce 6 □Other (Specify)
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
Hospita 24 hours Funeral	Medical C		death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the cau red at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month, Day, Year)
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	/Medic Examir		4a. Facility Name (If not institution, give s		<u> </u>	4b. City, Town, o	or Location of Deat	th How	4c. County	of Death	0100
	Funeral Director		Augsburg Luther 5. Social Security Number 427-16-0325 6. Sex		Home (a. last birthday) (Yrs.	Balt If Under 1 Year Months Days	imore If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D.	rth ay, Year) 2 21	9. Birthpl Count	lace (State or Foreign try) MS
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ם D	permit. Pages 1 and 2 should by Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic e Once.		21. Signature of Funeral Service License	Thompson	43	rch F/H 00 Waba	sh Ave,			nd 2	21215
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location City or To	(Street and Numb wn, State)	per or Rural	l Route Number,
	he Hospli n 24 hour he Funer pletely fill	Medical (29a. Certifier (Check only one) 1	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s) and ma e, date and place,	anner as stand due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	<		29c. Licens			29d. Date signe		
	1.1		30. Name and address of person who con	moleted trues of death (the	um 23a) /Tuna	Print)	13121	3	mga	1,2	००४
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	Sta Registr		31. Date filed (Monto) 73. (Pag 200	32 Registrar's Sign	nature	ale .					

DHMH 17 Rev 1/2001

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State Registrar Jenel S. Wyatt,

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who complete duse of death (Item 23a) (Type, Print)

32 Registrar's Signature

MD

D 62063

14207 Park Center Drive, Suite 102, Laurel, Maryland

March 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland		artment of Hear tificate of De			ene g. Noć) 🔒	0.0	10760
	201		Registrar 1. Decedent's Name (First, Middle, Last)		imodio or z c		2. Date of Death	, CU	U ö -	3: Time of Death
37 ₁	Physicia /Medic		AGNES F. TALTYS				APRIL		OO8	8:00 A. ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County	of Death	
			GOOD SAMARITAN NURSING HOME		BALTIMOR	RE CITY f Under 24 Hrs.	0 Data of Birth		N/A	Jane (Chata au Farrian
8	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) Yrs.		Hours Min.	8. Date of Birth (Month, Day,		Cour	- /
	Director		220-01-6415 '	110.			4/21/19	23	MARY	LAND
	land ow	ŀ		y, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sho	ğ	MD BALTIMORE	DARK	VILLE					1 □Yes 2 🟋 No
	the notif	rec	10e. Street and Number	IMU	10f. Zip Code		10	Og. Citizen of	What Cour	ntry?
	3a or		8131 GLEN GARY ROAD		2123	34		US	Α	
	death ms 2 r mus	Funeral Director	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		eclfy Yes or No- Rican, etc.)		ce - Americ	
9	after or ite mine	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No			Specify:	, ,	Specia		
ဗ္ဗ	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	3 ₩ Widowed 4 □ Divorced Year or Dates:						WF.	ITE
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12	withir	m m	Elementary/Secondary (0-12) College (1-4or 5+)		ICH HAND			FACT	ORY	
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aŭ	d be ental ced o	o Be	PETER FRANKOWSKI			FRANCE:	S ARENDI	`		
Maryland	shoul nd Me mari	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and				, State, Zij	Code)
Ž	nd 2 alth a		JOHN TALTYS/SON	8121	CLYDE BAN	NK ROAD	BALTIMO	RE, MD	212	234
Ē,	s1a of Hea item othe		20a. Method of Disposition 20b. F		osition (Name of matory or other place)		Date	20c. Location	- City or T	own, State
Ē	Page ient o nt: If		1X Burial 2 Cremation 3 Hemoval from State		SLAUS CEM.	1	2008	BALTIM	ORE	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2:	2. Name and Address	of Facility THI	E JOHNSO	N FUNE	RAL H	IOME, P.A.
m	permi Depar Impor any ir	0.0			521 LOCH F			SON, M		286
r			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on eac line.	th. Do not en	ter the mode of dying,	such as cardiac	or respiratory arre	est,		Approximate Interval Between
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1	/Medical		resulting in death) Due to (or as a conseq							4 Hauth
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Box	death certif e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)				lonth	Day Year
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	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not res	sulting in the u	ınderlying cause given	in Part I.	23e. Did tol	bacco use co	ntribute to	the cause of death?
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Vital	sician: Th certificate rector, pag		25. Was case referred to medical			26. Place of Deat		/."	10100	70
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Division	er de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Speci.	iome, farm, st ify)	reet, factory, office		28f. Location (S City or Tow		nber or Ru	ral Route Number,
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu									atata d
	Hosp 4 hou Funel ely fil	ledical	29a. Certifier 1 Certifying Physician: To the best of my know (Check only 2 Medical Examiner: On the basis of examiner	owledge, dea ation and/or i	th occurred at the time nvestigation, in my opi	e, date and place inion, death occu	, and due to the o rred at the time, o	cause(s) and r date and place	nanner as e, and due	stated. to the cause(s)
	the hin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number / /		29d. Date sigr	ned (Month	, Day, Year)
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	(1)		30. Name and address of person who completed cause of death (Item	21 VO	12 de	lliaw	re- 1	d-5	123	37.
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Sign,	ature A						-
	Reaist		APR 0 3 2008	ature						

Box 68760. P.O. Division or Vital Records.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** Frank Vollmerhausen /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** mit Baltimore Washington Medical Center If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 1**X** M 2□F Months Mar 14, 1925 83 Director 579-24-8769 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. Cify, Town or Location r 28a-f show notified at 10a. State 10b. County 1 □Yes 2X No Directo MD Howard Savage 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or adical Examiner must be r **USA** 20763 8580 Baldwin Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2□ No If Yes, Give Year or Dates:1943-46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Construction Inspector 8 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other i any Injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeannette Carr Conrad H. A. Vollmerhausen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2065 Duvall Road Woodbine, MD 21797 Luanne Rushing/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/02/08 Chesapeake Crematory Beltsville, MD Coing Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licensee K Litte Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1∏Yes 1∐ Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of De th 28a Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple 31. Date filed (Month, Day, Year) Registrar's Signature State APR 0 3 2008 Registrar

Registrar
DHMH 17 Rev 1/2001

State

Batimon.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

31. Date filed (Month, Day, Year)

APR 0 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year James Randolph Wiggins 8:40P. March 24,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Timonium

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Feb. 14, Baltimore Stella Maris Hospice 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) Months 1**X** M 2□ F 216-62-5874 1956 Maryland Director 52 Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21215 3718 Cottage Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 28 Married 21215-0036 Specify: Black 1 ☐Yes 2X No Specify: <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Industry Elementary/Secondary (0-12) College (1-4or 5+) Heating and Air Conditioner repair 2 Years Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Lawson Ben Wiggins ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 Cottage Avenue Baltimore, Maryland 21215 Veronica Queen-Wiggins/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/29/08 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Maryland 21215 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ine. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) **Physician** e. END STAGE LIVER DISEASE /Medical Due to (or as a consequence of): Examiner b. HEPATITIS C Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of). P.O. Box 68760 the attending physician the for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≦ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 □Yes 2 🕱 No 2 🗆 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the within 2 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 26108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.

32. Registrar's Signature DR. TARIO MAHMOOD TIMONIUM, MD 21093 State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month HAZEL JEAN LOUGH WATSON MARCH 26, 2008 8:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PEARTREE ASSISTED LIVING **PASADENA** ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 D M 2 14 Days Hours Yrs. Director 216.42.5175 39 NOVEMBER 10,1918 Usual Residence of Decedent show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Exerciner must be notified at Director 1 Tyes ZY No 28a-f ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or death v 376 HIDDENBROOK DR. Funeral 21061 USA items 12. Was Decedent Ever in U.S. Armed Forces 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2XX No Specify þ 3 Widowed 4 □ Divorced Specify: "natural" WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the any injury or other traumatic event, the angles. 12 HOME MAKER CENT HOME 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ HARRY LEE LOUGH BESSIE MARIE ANTILL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE M. MORRIS DAUGHTER 21 MADARY RD. SEVERNA PARK MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MD VET CEM CROWNSVILLE 4 ☐ Donation 5 ☐ Other (Specify) APRIL 1, 2008 CROWNSVILLE, ND ra Funeral Service Lice 22. Name and Address of Facility FINK FUNERAL HONE, P.A. GREGORY FINK M01148 426 CRAIN HWY S GLEN BURNIE, MD Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate se (Final TROKE Physician Year disease or condition resulting in death) ... Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 1∐Yes 2∭XXo 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2√√ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 □ No 1 □ Yes 2/X No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 XXIo Other: 4 \sum Nursing Home Other (Specify) ASSISTED Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 28a. Date of Injury (Month, Day, Year) LIVING 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 24 hours after deatle Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide **XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year)

State Registrar Maderm

deause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** : 40 Dennis James Watkins 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Baltingra Washington 8. Date of Birth (Month, Day, Year) 06-19-1943 If Under 5. Social Security Number **Funeral** 1**⊠**M 2□F Days Hours MD 219-38-2705 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director MD Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 809 Marley Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married white 1 ☐ Yes 2X No Specify: Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tattoo Artist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Catherine Eastwood James Maurice Watkins Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. 809 Marley Avenue; Glen Burnie, MD 21060 Mrs. Gale E. Watkins / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 04-03-2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Ave SW; Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) netast /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 TYes 2 NO the Hospital or Attending Physiclan: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours at To the Funeral E completely filled i

Jenni

State Registrar 31. Date filed (Month, Day, Year) APR 03 2008

29b. Signature and title of certifier

29a. Certifier

Medical



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

m()

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24781

29d. Date signed (Month, Day, Year)

March

2008

	1 - For State Registrar			,	Department of F Certificate of			giene Reg. No. 2 A A A	1076
ic i an	Decedent's Nar	me (First, Middle,	Last)				2. Date of Dea		3. Time of Death
dical	Paula		Maxine		Williams		March	30, 2008	
niner		(If not institution, g ilton Av	give street and number)			r Location of Death		4c. County of Dea	
-1	5. Social Security			e (In yrs. last b	Glen Bur	If Under 24 Hrs.	8. Date of Birt	Anne Ar	
al or	510-52-	4114	1□M 2X1F	58	Yrs. Months Days	Hours Min.	Sept. 2	24,1949 C	thplace (State or Forei ountry) Kansas
	10a. State	10b. County		10c. City, To	wn or Location				10d. Inside City Limit
to:	MD	Anne A	runde1	Glen	Burnie				1 □ Yes 2X N
Director	10e. Street and N	umber			10f. Zip Code			10g. Citizen of What Co	ountry?
<u></u>	308 B M	ilton Av			21061			U.S.A.	
Funeral	11. Marital Status		12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	lisp <i>a</i> nic Origin? (Sp an, Mexican, Puerte	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whi	
Š	3 ☐ Widowed	rried 2 Married 4 Divorced	d 1 □ Yes 2 🔼 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:		Specify: W	hite
Be Completed	(Spe	15. Decedent's ecify only highest		16	 Decedent's Usual Occup (Give kind of work done life. DO NOT use retire) 	oation during most of work	king	16b. Kind of Business	/Industry
d d	Elementary/Sec	condary (0-12)	College (1-4or 5	5+)	Disabled	d)		Disabled	
ਤੌ	17 Father's Name	e (First, Middle, La			Disabled	18 Mother's Nam		Maiden Surname)	
Be	F ₁₁₀ 11 I	Kendrick	151/				eth Haye	ŕ	
2		Name/Relationship	(Type Print)	10	b. Mailing Address (Street				Zin Code)
			ifele/Daugh		46 Patuxent				210 0000)
	20a. Method of Di		ilele/ Daugn	20b. Place	of Disposition (Name of	i	Date	20c. Location - City or	r Town, State
	1 ☐ Burial 2	2 Cremation 3	Removal from State		ery, crematory or other pla peake Cremat		2009	Stevensvi	110 MD
all		5 ☐ Other (Spe Funeral Service Li		Chesa				Funeral &	
ouce	100	1 mm	W Waik	21170	Services	1 2nd Ave	enue SW	Glen Burni	e. MD 21061
in al er	shock, or he Immediate Cause disease or condit resulting in death Sequentially list of fany, leading to cause. Enter Unc	eart failure. List or e (Final ion)	a. Due to (or as	a consequence	o not enter the mode of dying the content of the co	l'Infe	ivetion	^	Approximate Interval Between Onset and Death India Ale
ical Examiner	cause. Enter Und Cause (Disease of that initiated even resulting in death)	or injury hts	cDue to (or as	a consequence	e of):				,
	that initiated even	ent pregnant 2 months?	c	e pf pregnancy 2 □ Fetal dea		у		23d. Date of de Month	elivery Day Year
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/Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	For	State of Marylan				id Mental H	ygiene		
	1 - State Registrar		Cei	rtificate of	Death		Reg. No.	2008	10770
	1. Decedent's Name (First, Middle, Last)					2. Date of I		Year	3. Time of Death
an cal	FRANKLIN DELA	NO WETHERING	TON, J	R.		March	Day 28	2008	5:30 P M
er	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of D	Death	4c. (County of Death	
	Laurel Regional Ho	spital		Laurel			Pi	rince Ge	eorge's
	5. Social Security Number 6. Sex	0 1 7	last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E	Birth Day, Year)	9. Birth	place (State or Foreign
	252-19-8357 ¹ X]M 2□F 45	Yrs.	Months Days	Hours N	Min. (Mo <i>nth, l</i> July			intry) Cqia
	Usual Residence of Decedent								
_	10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
Director	MD Prince Ge	orge's La	urel						†XXYes 2∐ No
ë	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?
a E	8220 Harvest Bend	Lane, Unit	#41		20707	,		USA	
ner		12. Was Decedent Ever in U.		Was Decedent of F		? (Specify Yes or Note: Puerto Rican, etc.)	10- 1	4. Race - Ameri	can Indian,
2	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				uerto Hican, etc.)		Black, White,	, etc.
b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 27∏ No	Specify:			Specify: Wh	nite
ted	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occur	pation		16b. Kin	nd of Business/Ir	ndustry
음	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done DO NOT use retire	auring most of d)	working			
Completed by Funeral	12th		Ca	r Salesma	an		Į P	Automoti	ve
Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd			
To E	Franklin Delano We	etherington,	Sr.		Ma	riam Coo	per		
F3	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailin	ng Address (Street		or Rural Route Num		Town, State, Zi	p Code)
	Marla D. Wethering	gton/Wife	8220	Harvest	Rend I.	ane IInii	- #17	Laurol	, MD 20707
-	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of	i	Date		cation - City or T	
	1 ☐ Burial 2√☐Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other pla ndel Cren	,	1/2008	0400	nton, MD	
	21. Signature of Funeral Service License					Donaldsor			
	aminox	PYYO UMO110							
	23a Part1 First the disease or complia					ue, Laure		20707	Approximate
	23a. Part1. Em a the disease, or complic shock, or mart failure. List only on Immediate Caose (Final	se on each line.	ii. Do not cita	or the mode or dyn	ig, suon as car	rdiac of respiratory	arrest,		Interval Between Onset and Death
	disease or condition resulting in death)	_Atherosclere		ardiovaso	cular H	eart Dise	ease		
		Due to (or as a consequ	uence of):						
<u></u>	Sequentially list conditions,	Due to (or as a consequ	ionoo of):						
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	derice or).						
xan	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):						
H		Dae to (or as a consequ	zence orj.						
di Gi	d.								
Me	IF FEMALE:	On these automores of many							
ian,	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregna 1 ☐Live birth 2 ☐ Fetal	Ideath 3□	Ectopic pregnancy	/		23	 Date of deliving Month 	ery Day Year
Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at time of de 9□Unknown	eath 5∟	Other (specify) _				Month	Day rear
P.	Part II. Other significant conditions conf	tributing to dooth but not you	ulting in the com		- in Book I	00- Pi-	4-1		
þ		thouting to death but not resu	nung in me un	idenying cause giv	en in Paπ i.				he cause of death?
Completed by Physician/Me	Diabetes					_ 1L	Yes 2]No 3∏Prol	bably 4 Unknown
ᇛ						24a. Wa	s an	24b. Were auto	opsy findings available
E O							formed?	death?	mpletion of cause of
Be	25. Was case referred to medical				26. Place of	Death (Check only	MM	1 1 1 1 1 1 1 1	2/XNo
.0	examiner? XXYes 2□ No	ospital: 1 ☐ Inpatient 2 ∑ N	ER/Outpatient	t 3 DOA Oth	or:	ng Home 5 ☐ Res		□Other (Speci	fu)
=	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur Wor		28d. Describe			(9)
ig	XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	!njury		K? Yes 2 □ No				
fice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho		eet, factory, office		28f. Location	(Street and	Number or Run	al Route Number.
erti	4 Dhomiage	building, etc. (Specify	")			City or To	own, State)		
<u>a</u>	29a. Certifier 1 ☐ Certifying Physi	icían: To the best of my know	wledge, death	occurred at the tir	ne, date and p	lace, and due to th	e cause(s) a	and manner as s	atated,
Medical Certification: To	(Check only XX Medical Examin	ner: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my o	pinion, death o	occurred at the time	e, date and	place, and due t	to the cause(s)
Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
1	122-11/10	loster 20			H0053	927			
-	1		22a) /T: =		.,	100	Mai	rch 31,	2008
- 1	30. Name and address of person who con	inpleted cause of death (Item	∠Ja) (Type, F	-11111)					

State

Registrar

Salvador Sylvester,

APR 0 3 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

3001 Hospital Drive, Cheverly, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			e of Death	and Men	• •	eg. No. 200	8 1077
Physic Medical Exam			arroll		Wat a	on	2. Date of Dea Month March 31,	th	3. Time of Death 0735 hrs
		4a. Facility Name (if not institution, g			Wats	vn, or Location o		4c. County of Deat	
·		2617 North Point Boulev			Dundal	K		Baltimore Co	
Funeral Director				yrs. last birthd	ay) If Under Months	1 Year If Under Days Hours	Min.	th(MM/DD/YYYY) 9. Bi Forei	n Bryan
		Usual Residence of Decedent	X M 2 F	38	Yrs.		August	13 , 1969 c	Texas
* any		10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ţ	Texas Willia	nson	Round					1 Yes 2 No
ne Mar or 28a fied at	Director	10e. Street and Number 17 Valley Creek	rivo		10f. Zip C	78664	1	0g. Citizen of What Cou	ntry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 71 is marked other than "natural", or items 23a or 28a-f sho with event, the Medical Examiner must be notified at once.	ral	11. Marital Status	12. Was Decedent Ever	in U.S. 1			n? (Specify Yes or No	USA 14. Race - Amer	ican Indian, Black,
r death or iter must	Funeral	1 Never Married 2 Marrie	1 Yes 2X	No			Puerto Rican, etc.)	White, etc.	
ırs afte ural",	ρ	3 Widowed 4 XDivorce 15. Decedent's Education (Specify	d If Yes, Give Year or Dates:		1 Yes 2 X	No specify:	ind of work done	Specify: WI	nite
5 72 bou n "nat	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)		ing most of working			Tob. Kind of Business/	industry
003(within giene. ner tha	Completed	12 years 17. Father's Name (First, Middle, Las		Li	neman			Electrica.	1
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", e event, the Medical Examiner.	Be C	William Milton W				1	Name (First, Middle, M Bra Kaye Ea		
21, hould the nd Men is mar	10	19a. Informant's Name/Relationship				Street and Numb	per or Rural Route Nun	nber, City or Town, State	
, MD and 2 sho eatth and em 27 is		William Milton Wa			Valley Disposition (Name		Date Date	Rock, Texa	
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If itiem 27, is narked c injury or other traumatite event, di		1 X Burial 2 Cremation 3	Removal from State	crematory	or other place) enorial Pa		April 8,	Pflugerville	·
altin mit. P. partme portan ury or	7	4 Donation 5 Other Special Signature of Funeral Service Los	/				2008	_	•
		Jusanes			Connell 7110 So	y Funera llers Po	al Home of oint Road,	Dundalk,P.A Dundalk,MD	A. 21222
Physician 'Medical		23a/ Party. Enter the disease, or confailure. List only one cause on	ach line.	leath. Do not e	nter the mode of o	ying, such as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	Carbon Monoxide P Due to (or as a consequer						Death
	<u>.</u>	ocquentially list conditions,	-						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequer	nce of):					
ited J ansit	Еха	events resulting in death) Last	Due to (or as a consequer	ice of):		-			
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED						
760, ficate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy				23d. Date of deliver	<u>, </u>
ox 68 eath certifi	/sician/	past 12 months?	1 Live birth 4 Pregnant at time	of death 5	Fetal death Other (Specify		pregnancy	Month I	Day Year
he de hed f	Phys	1 Yes 2 No 9 Unknow	9 Unknown						
ires that the signed by	ģ	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying ca	use given in Pari		bacco use contribute to	
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed						24a. Was a	an 24b. Were au	itopsy findings available
eco he law ate has	omp		··				autop		completion of cause of
tal Recian: The	Be	25. Was case referred to medical examiner?			26.	Place of Death (C		2 10 1	es 2 No
f Vid Physic er this	ဥ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2					Residence 6 🗸 Othe	r: Scene
on of inding P ath. r: After he funera	tion:	1 Natural 5 Pending	FOUND: Day, Year)	FOUND): 1	Injury at Work? Yes 2 ✓ N	Inhaled Car	now injury occurred Exhaust	
Division pital or Attendir ours after death.	Certification:	2 Accident Investiga 3 Suicide 6 Could not	29a Place of Injury	0717 hr At home, farm,			28f. Location (S	Street and Number or Ru	ral Route Number, City
Di e Hospitat 124 hours a e Funcral I etely filled	Cer	4 Homicide determine	(Specify) Parking					oint Boulevard, Dunda	
the plet	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ✓ Medical Examine	ian: To the best of my known: On the basis of examination	vledge, death on and/or inves	occurred at the time stigation, in my op	e, date and plac	e, and due to the cause urred at the time, date a	e(s) and manner as state	ed. e cause(s)
To vition con	Mec	29b. Signature and title of certifier	and manner stated.			cense number		29d. Date signed (Mo.	
		E	1h		C	.C.M.E.		April 1, 2008	
		30. Name and address of person who David Fowler M.D. Chie	completed cause of death (,	n Street, Balti	more MD 0	1201		
St	ate	31. Date filed (Month, Day Year)	32 Registrar's Sig		oreet, Balti	more, MD 2			
Regist	rar	31. Date filed (Month, Day, Year) APR 0 3 2	008 Berene	St A	as well				

			For State Registrar		State	of Ma	ryland		artment rtificate				lental H	ygien Reg. N	$\sim 5.0 \pm 0.0$	10	772
10			Decedent's Nam	e (First, Middle, L	ast)		-						2. Date of I	Death	ay Year	3. Time	of Death
	Physicia /Medic		Eduardo A	nchiraic	0									15.	2008	2:4	45 A ^M
	Examin	-	4a. Facility Name (lf not institution, gi	ve street and no	umber)			4b. City, 7			of Death			c. County of Deal		
Ä			180 Talbo		t #101 Sex	7. Age	(In vrs. la	st birthday)	Rocky If Under		e if Under	24 Hrs.	8. Date of I	Birth	Iontgome	⁻y hplace <i>(St</i> at∈	or Foreian
	Funeral Director			N/A	1 ∑ M 2□F		6	Vre	Months	Days	Hours	Min.		Day, Yea	1947 Peri	untry)	J
	p		Usual Residence o	f Decedent		1		Town or Lo	ontion							10d. Inside	City Limite
	shov sd at	ō	10a. State MD	Montgom	erv			ville	Cation								s 2 No
	the N	Director	10e. Street and Nu	_					10f. Zip	Code					Citizen of What Co	untry?	
	23a or ust be		180 Talbo	tt Stree	t #101				2085	52				Per			
2	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 🔀 Married 4 □ Divorced	12. Was De Armed F 1 Tes If Yes, G Year or	Forces?			Was Deced If Yes, spec 1 ∰ Yes 2		ispanic O an, Mexica Specify		ecify Yes or Rican, etc.)	No-	14. Race - Ame Black, Whit		
5	2 hou natura ical E	ted	(Sno	15. Decedent's E	Education		-	16a. Deced	dent's Usua	l Occup	ation			16b.	Kind of Business		
į	ithin 7 ne. nan "r e Med	Completed	Elementary/Seco			(1-4or 5+	+) -	ا '' _{life} Mechaı	kind of wor DO NOT us nical				ng	Fac	ctory		
7	Hygier Hygier ther th	S	17. Father's Name	(First Middle Las				- Incernation					(First, Midd		en Surname)		
0	ld be lental ked o	To Be	Francisco									el Ag		,	,		
2	shou and M s mar		19a. Informant's N	ame/Relationship	(Type. Print)				•	•					y or Town, State,		
			Karina Ar		/daught	er					reet				e, MD 20		
2	ages 1 nt of H : If ite			Cremation 3		n State	ce	ace of Dispo metery, crei	natory or ot	ther plac	· i		Date O / O O		Location - City or	•	
	permit. Pages 1 and Department of Healti Important: If item 2; any Injury or other 1 once.		4 □ Donation 21. Signature of Fi	5 Other (Specuneral Service Lice		1,	Che	sapeal					.8/08		P.O. B		
ב	Dep Imp any		1/201	self f.	Hell	the	- -мо12								larksvil		21029
			23a. Part1. Enter	the discase, or con art failure. List onl	mplications that y one cause on	caused t	the death. e.	Do not ent	er the mode	e of dyin	ig, such a	s cardiac	or respiratory	y arrest,	10.C1 - W - 2.22 - 1 - 1	Approxim Interval B Onset an	ate letween
	Physician		Immediate Cause disease or condition resulting in death)	(Final on	a End S				sease							Oliset all	d Death
	/Medical Examiner		, cooming in county				conseque	ence of):									
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	scuted ind transit	Examiner	cause. Enter Under Cause (Disease or that initiated event resulting in death)	r injury	C												
5	icate be executed physician and s the burial-transit	a E	resulting in death)	Last	Due to	o (or as a	conseque	ence of):								,	
	ificate g phys	edical			d												
O. DO.	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ysician/M	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months? □ No		birth 2 gnant at t	of pregnan 2 Fetal time of de	death 3	□Ectopic pre □ Other (spe		′			-	23d. Date of de Month	livery Day	Year
	s that i	by Phys	Part II. Other signi	ficant conditions	contributing to	death but	t not resul	ting in the u	nderlying ca	ause giv	en in Part	l.	23e. Di	id tobacc	o use contribute t	o the cause o	of death?
5	require												1	Yes	2 ™ No 3□ P	robably 4[Unknown
	: The law cate has be page 2 sh	Completed											p∈	as an utopsy erformed x	prior to death?	utopsy finding completion o	s available f cause of
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5	arth. or: Afte	atio	1 □ Natural 2 □ Accident	5 ☐ Pending investigation	on	onth, Day	rear)	Injury	М		kr Yes 2□]No					
2	or Atter fter de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	4 200. Flac	ce of injur iding, etc.	ry - At hon . <i>(Specify)</i>	ne, farm, str	eet, factory	, office			28f. Location City or	n (Street Town, St	and Number or Fi ate)	ural Route N	umber,
2	spital ours a neral t		29a. Certifier	1 X Certifying F	hysician: To th	he best of	f my know	/ledge, deat	h occurred :	at the tir	me, date a	and place,	and due to t	the cause	e(s) and manner a	s stated.	
	n 24 h he Fui pletely	Medical	(Check only one)	2☐ Medical Exa		basis of a		on and/or in	vestigation,	, in my c	opinion, de	eath occur	red at the tin	ne, date	and place, and du	e to the caus	e(s)
	withi To tl	Ž	29b. Signature and	title of certifier	/1	//	2	1	2		e number			1	Date signed (Mon)
			1 /or	Ruge	Uno	Ms	WW S		-7	4615)			Ma	rch 17,	2008	
),	a2—		30. Name and add	e Wroblev	vski, M	.D. 1	1355	Picca		ive	Rock	ville	e, MD	2085	0		
	Sta Registr		31. Date filed (Mor	MAR 1 9		6	r's Signati		and a	,							
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							Copies Are	_	
			For	State of Maryland	•		ental Hygier	ne o o o	10770
			1 - State Registrar		Certificate of	Death	Reg. I	46.UU8	10/13
	nysici: Medic		1. Decedent's Name (First, Middle, La	Lolita	AdKin	S	2. Date of Death Month March	Day Year 15. 2008	3. Time of Death 4:30AM
	kamin		4a. Facility Name (If not institution, gir	3 1 4 1		or Location of Death	4	4c. County of Dea	th
Fur	neral			Sex , 7. Age (In yes last		otreville	8. Date of Birth	Jueen ,	Thyles thplace (State or Foreign
Dire	ector		220-52-0302 Usual Residence of Decedent	1□M 218 59	Yrs. Months Days	Hours Min.	Oct. 23	ar) Co	aryland
yland	둭		10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
89-1-8	petitio	ctor	MD. Queer	Anne's (SYASON!	1:11e			112 Yes 2 □ No
.0036 hours after death with the Maryland ture!', or Itama 23a or 28a-1 show	intracreast be notified at	by Funeral Director	10e. Street and Number	nville terrac	10f. Zip Code	1638	10g. (Citizen of What Co	ountry?
deat	THE STATE OF THE S	ner	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of I	1 4 0 0	cify Yes or No-	14. Race - Ame	
after after or its	a a	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give	1 Yes, specify Cub	an, Mexican, Pueπo F Specify:	rican, etc.)	Black, Whit	e, etc.
15-0036 72 hours af "natural", or	3		3 ☐ Widowed 4 ☑ Divorced	Year or Dates:				, ,	ack
within 72 lene.	Modical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	ng 16b.	Kind of Business	findustry
d 21 filed wit Hygiene	4	Com	25	Odilogo (1 40) 04)	000	K	S	tate (Gov.
	8	Be	17. Father's Name (First, Middle, Last			18. Mother's Name	(First, Middle, Maide	en Sumame)	11
	natic	ဥ	revcy c	D. Williams		Anna	Belle	Hur	dle
and 2 shou saith and M	rtraun		19a. Informant's Name/Al lationship	AdKins	19b. Mailing Address (<i>Street</i>	and Number or Rural	I Route Number, City	or Town, State, I	Zip Code) MD, 21601
Ore, es lar of Hea	othe		20a. Method of Disposition	20b. Place	e of Disposition (Name of etery, crematory or other pla	ce) D	ate 20c.	Location - City or	Town, State
Pag Pag ment ant: i	ury or		1 ØBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	_Hemoval from State 🏲	Ian's Cemet	ery 3/2	0/08 G.	rasonvi	lle, MD.
Balt permit. Depenter Imports	eny in		21. Signature of Funeral Service Lice	nsee n	22. Name and Addre	ss Facility -unera	1 Home,	P.A.	,
- 40 E	es O		Janelle	C' Sterry	1510 Wa	Shinator	USt. COM	in bridge	,
Dhami			23a. Parf. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Do not enter the mode of dyl	ng, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)	a. Due to (or as a consequent	ce of):				days
Exam	iner		Supposite the New William	. Dermatit	is, estology	unclear			Weeks
pe	Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):				
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	Ë		resulting in death) Last	Due to (or as a consequent	ce of);				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Celeste B. Black 03:25 A^M 2008 APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 21, 1922 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 1 ☐ M 2 🛛 F 156-16-3770 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Director Baltimore Freeland MD 10g, Citizen of What Country? 10e Street and Number 10f Zin Code U.S.A. 21053 20501 Gore Mill Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Office Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myron Walter Beulah Woodbury 19a. Informant's Name/Relationship (Type. Print) Jerry Lee Blevins , Representative 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 Bentley Rd., Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) Cremation Direct Service 20a. Method of Disposition Date 20c. Location - City or Town, State April 2008 1 Burial 2 N Cremation 3 Removal from State York, PA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 auss 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a, Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation

death certificate be executed burial-transi and Box 68760 attending physician the as ase s P.O. signed by the Records. been page 2 s Division or Vital

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other train matic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other tra m

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

certificate has funeral director, this Hospital or Attending P 4 hours after death. After filled in by the To the Hospital of within 24 hours af To the Funeral D Medical

31. Date filed (Month, Day, Year) APR 03 2008 Registrar

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Joanna Bell 3/27/2008 P^{M} 6:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F 65 115-22-5618 12-14-1942 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYes 2 XINO Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10512 Weymouth St. Apt#3 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Optmologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Quanjer Helen Hazell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie H. Reese Old Bridge Ln Jefferson, MD 21755 Daughter 4107 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem 4/1/2008 Frederick, MD 22. Name and Address of Facility Keeney & Basford P.A.F.H. 21. Signature of Funeral Service Licensee he Zhr M01222 106 East Church St. Frederick, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of the Pancrease 8 Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner** Maych 27,2008 requires that the death certificate be execut burial-tran o signed by

Joanna

or Vital Bell,

or Attending Physician:

After this certificate has

within 24 hours after death.

To the Funeral Director; completely filled in by the 1

Physician

/Medical

Examiner

10a. State

MID

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Medical Certification: To Be Completed by

			1 ☐ Yes 2 ☐] No 3 ☐ Probably 4 🔼 Unknown
			24a. Was an autopsy performed? 1□ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 ☐ Yes 2X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hon	ne 5 Residence 6	Other (Specify)
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	8d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ctory, office 2	8f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of my knowledge, death occu miner: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, a ation, in my opinion, death occurre	and due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d Date	signed (Month Day Year)

D 516/6

3/28/2008

State Registrar

31. Date filed (Month, Day, Year)

Kali1

Nelson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454

Wisconsin Avenue Suite 1300 Chevy Chase MD 20815 32. Progistrar's Signature

DHMH 17 Rev 1/2001

1016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 03 23 2008 0300 Robert Trvin Burkett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland WMHS-Braddock Campus If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7, Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min. Hours 1 X M 2 □ F Months Days 04-30-1939 Maryland 68 Director 212-38-5231 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f sho 1 Yes 2 No Director MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21502 12112 Cash Valley Road NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No 1959 ← If Yes, Give Year or Dates: 1961 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) <u>Track Maintenance</u> Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. Be Leola McKenzie Burkett Trvin W. Burkett 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12112 Cash Valley RD NW Cumberland MD 21502 Mary Louise Burkett wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 03-27-08 LaVale, MD 21502 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. Sowers runeral Holes Holes Market Market St., FROSTBURG, MD 21532

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 16 days mesenteric ischemia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Acute renal failure page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sepsis has autopsy certificate 1 ☐ Yes 2 ☐ No 1∐Yes 2∭ No Respiratory failure funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After I filled in by the funera After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) of certifier 29b. Signatur D0018216

State Registrar

DHMH 17 Rev 1/2001

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900 Seton
31. Date filed (Month, Day, Year)

APR 0 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Division or Vital Records, P.O. Box 68760,

	Please Type or Pri					-				
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/land ow at	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits			
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permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must be once.	11. Marital Status 12. Was Decedent Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▶ 1 □ Yes 2 ▶	Ever in U.S. 13	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
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Daltillo	permit. Pages Department of Important: If if any Injury or conce.		21. Signature of Funeral Service Lice	nsee // ba /	22	. Name and Addre	ss of Facility Hart	zler F	uner	al Home		
•	20 E # 9		Catharine (. Harleer		10 Churc				, MD 217		
	3,457		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that wased the death one cause on each line.	n. Do not ente	er the mode of dyir	ng, such as cardiac or	respiratory ar	rrest,		Approxima Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition	. Hepat	ic t	allu	re				Of au	Death
	/Medical Examiner	Н	resulting in death)	Due to (or -s a consequ							- (1
	Exammer	L	Sequentially list conditions,	b	175%							
Ť	p tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ware)	Due to (or as a consequ	uence of):							
	ecute and trans	am	that initiated events resulting in death) Last	C								
Š	e exisan sian surial		Todaling in doubly add	Due to (or as a consequ	uence or):							
00/00	ate b hysic the b	lica		_d								
	entific ing p	Med	IF FEMALE:							,		
ל מ	ath c ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3□	Ectopic pregnancy	y		1.4	23d. Date of deliment	very Day	Year
5	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5□	Other (specify)					,	7 0 0.1
-	hat the deby detacl	Physician/Medical	Part II. Other significant conditions	contributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did to	ohacco i	use contribute to	the cause of	death?
COI CO	signe signe	Completed by	Ob Anothing	aundice		anho	+1			□ No 3 □ Pro		
5	requ	etec	+1.0/01/		00	1 1-1	1 - 2+ (1)					
ב	has l	d m	coromocyp	pena co	noce	cyson	SSTAKE	24a. Was autor		24b. Were aut prior to c death?	ompletion of	cause of
<u></u>	r: Th	Ö	diasetes une	ellins, a	was	Duyo	pathy	1□ Yes	2 ₽ Ño	1 ☐ Yes	2□M6	
אונס	certif	Be	25. Was case referred to medical examiner?	Hospital:		t 3D DOA Oth	26. Place of Death (
5	Phys	- T	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	28b. Time of	. 0000	4 LI INGISHIO OITH	e 5 ☐ Resid d. Describe I			eify)	
5	ding I. After fune	ion:	Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	ia. Dodoniso i	now myan	ry occurred		
0	death ctor: / the	ical	3 ☐ Suicide 6 ☐ Could not b	e lan Blace of injury. At he	me. farm. stre			f Location (5	Street ar	nd Number or Ru	ral Route Nu	mher
2	after after Dire	Certificatio	4 ☐ Homicide determined	building, etc. (Specify	v)	,		City or Tov	vn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Pl	nysician: To the best of my kno	wledge, death	occurred at the ti	me, date and place, ar	nd due to the	cause(s) and manner as	stated.	
	e Ho e Fu letely	Medical	(Check only one) 2 Medical Example (Check only one)	miner: On the basis of examina and manner stated.	tion and/or inv	vestigation, in my	opinion, death occurred	d at the time,	date an	d place, and due	to the cause	(S)
	To th Withir To th	Me	29b. Signature of title of certifier	0 6. 0		29c. Licens	se number		29d. Da	te signed (Month	, Day, Year)	
,			1 1/4 /10	y, tock		13	6845	(Mi	arch 2	8, 2	200
			30. Name and address of person who	completed cause of death (Item	1 23×a) (Type, I	Print) MO	ri-Cli ?	Low	yei	2, MIT,	, FC	CP
			7350 grace	2 Prive 1	Colu	mbra	, MD	2000	44			V
	[⊕] Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		7		1			
	Registr	ar	APR 0 3 2008	Mars 10 18 1	20481							
DH	MH 17 Rev 1/20	001	and the same of th									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2050 P.M.

Birthplace (State or Foreign Country)
 Ireland

10d. Inside City Limits

1 ☐ Yes 2 🖫 No

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

attending physician and for use as the burial-transit requires that the death certificate be executed the ģ certificate Hospital or Attending Physician: filled in by the funeral director, this After 24 hours after death Puneral Director: within 2. the

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

0

and manner stated.

600

29c. License number

NO 056890

Denue Franswick

29d. Date signed (Month, Day, Year)

3/13/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Martha Elizabeth (Rephann) Burkentine March 23. 2008 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 402 Webb Lane Havre de Grace Harford If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 23, 1926 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 X F 212-24-1500 81 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits show at "natural", or items 23a or 28a-f sh edical Examiner must be notified 1 ∑Yes 2 □ No Director Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Webb Lane U.S.A. 21078 If item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White. Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Production Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Lee Rephann Gladus Eise ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any Injury or other trau Dorothy Dahl (Daughter) 402 Webb Lane Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 3/31/2008 West Chester, PA 22. Name and Address of Fecility Zellman Funeral Home, P.A. 21. Signature of Fune al Service Lice <u>123 S. Washington St. Havre de Grace.</u> MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar and Due to (or as a consequence of) **3** Records, P.O. Box 68760, attending physician Physician/Medical as the I esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for 1 Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Tes 2∏ No 3 Probably cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform certificate I 1□ Yes 2□No Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 TYes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Po 24 hours after death. e Funeral Director: After the letely filled in by the funera After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 5. Union Avenue HOG, MD21078 31. Date filed (Month, Day, Year) gistrar's Signature State MAR 25 Registrar The same

DHMH 17 Rev 1/2001

		For State Registrar		-	artment of F rtificate of		Reg	g. No. 2008	1078
Physicia /Medic	_	1. Decedent's Name (First, Middle, Las Vernetta Burch	•				2. Date of Death Month 3 1.	Day Year	3. Time of Death 9:15 a M
Examin		4a. Facility Name (If not institution, give		r	4b. City, Town, o	r Location of Death		4c. County of Dea Dorches	
Funeral Director		5. Social Security Number 6. Se 380 – 46 – 2477	7. Age (In 104	yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11 1 - 4 - 1)	9. Birl 903 St.	hplace (State or Foreign buntry) Md • Michaels;
W #		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
when it is noted states desail with the mary and than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ctor	Md Dorche	ester C	ambridg	re ,				1X Yes 2 No
or 28	Director	10e. Street and Number			10f. Zip Code	2		g. Citizen of What Co	ountry?
ns 23a must	Funeral	520 Glenburn Av	7e . 12. Was Decedent Ever	in U.S. 13.	2161 Was Decedent of H			USA 14. Race - Ame	rican Indian,
Department or heath and whether righted: University is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☐ No	an, Mexican, Puèrt Specify:	o Rićan, etc.)	Black, White	_{e, etc.} Black
natura Jical E	Completed	15. Decedent's Ed	ucation de completed)	(Give	edent's Usual Occup kind of work done	during most of wor		6b. Kind of Business	Industry
han "	mple	Elementary/Secondary (0-12) 11 years	College (1-4or 5+)	life.	DO NOT use retired	d)		private	homes
event, th	To Be Co	17. Father's Name (First, Middle, Last) George Harvey		Dome	SCIC		ne (First, Middle, M ia Field	laiden Surname)	
is marke raumatic	2	19a. Informant's Name/Relationship (1) Janet Goldsbord	ype. Print) Sugh (niec	e) P. (ing Address (Street	and Number or Ru 24, St.	ral Route Number, Michae	City or Town, State,	Zip Code) 21663
tem 27		20a. Method of Disposition		Ob. Place of Disp	osition (Name of	1 1		Oc. Location - City or	
nt: if if		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		ematory or other pla Thomas		7-2008	St.Micha	els,Md
importa any inju once,		21. Signature of Funeral Service Licen	see C	2	2. Name and Addre	ess of Facility		7 **-	D.C.
7		23a. Part1. Enter the disease, or companion, or heart failure. List only	lications that caused the one cause on each line.	death. Do not er	iter the mode of dyli	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
ician		disease or condition	a. Conges	tive 1	heart 7	failure			Onset and Death
dical iner		resulting in death)	Due to (or as a co	nsequence of):	heart t	info	ction)
	Jer	Gequentially flet conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	Corwa	, &	aren		
s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	nsequence of):					
shysici the bu	edical		d						
igned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐	Fetal death 3	□Ectopic pregnanc	у		23d. Date of de	livery Day Year
chedi	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	e or death 5	Other (specify) _				
e deta	by Pi	Part II. Other significant conditions of	-	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did tob		o the cause of death?
should		dementie					1 □ Ye	s 2∏No 3∏P	robably 4 □Unknow
S CV	Completed				<u></u> -		24a. Was an autopsy perform	y prior to	utopsy findings availabl completion of cause of s 2 No
director, page	Be C	25. Was case referred to medical examiner?	1114-1		law		ath (Check only one	9)	
ral dire	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 Liprursing F	lome 5 ☐ Reside	nce 6 Other (Spe	ecify)
e funera	tion	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye		Wo	rk?]Yes 2 □ No	200. Describe no	w Injury occurred	
d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - building, etc. (S		treet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	ural Route Number,
To the Funeral Director : After th completely filled in by the funeral	Medical C		ysician: To the best of m niner: On the basis of exa and manner stated	mination and/or					
compl	Me	29b. Signature and title of certifier	A 2		29c. Licens		1	9d. Date signed (Mon	
		* Baluco	200		Ho	05997	3	3/13/0	8
		30. Name of address of person who Patricia John		(Item 23a) (Type	Print)	nheida	e MD)	
	7 î	Patricia John	SOVI IVU	NICHTIN	C 001	1101100			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20, 2008 **Physician** Pritchett Bramble Louise March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorches Dorchester Cambridge
If Under 1 Year If Under 24 Hrs. Hospita Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 ☐ M 2 🔀 18, Maryland Nov. 1919 88 Director 214-12-5937 Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show iner must be notified at 1x Yes 2 □ No Cambridge MD Dorchester Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 USA 802 Glasgow Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white ō 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Department of Health and Mentioned Bright and Mentioned of Health and Mentioned any Injury or office. Areida Meredith Hillary V. Pritchett P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5513 Mallard Lane, Cambridge, MD Philip L. Bramble Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/24/08 Hurlock, MD Maryland Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature/of Funeral Service Licensee Thomas Funeral Home P.A. h h J loron 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardio my of athy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner equires that the death certificate be executed di sease COPONAY AT Due to (or as a consequence of) g physician and as the burial-trans artery Box 68760. Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Year Day ō in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ tibullation 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Mo has page 2 certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA 1 Impatient P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge MO Bramble Johnson 31. Date filed (Month, Da Registrar's Signature Pay, Year) 2008 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, b, 25 per me, 2878, 04/14/08dhb

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 21, 2008 March 8:45 A M Margaret Beasley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Citizens Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Days 213-22-4596 82 Jan. 11, 1926 Maryland Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☑ No Director MD Garrett McHenry 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 362 Pysell Rd. USA 21541 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Clerical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jonas Glotfelty ျ Mary Jane Frazee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1325 Mulberry Ct., Frederick, MD Matthew G. Beasley/Son 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Oak Grove Cemetery March 25, 2008 McHenry, MD

22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee ju P.O. Box 275, Grantsville, MD umau W 23a. Part1. Enteyth disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death thrombo afto penic Immediate Cause Final PUYDWA Physician YEARS disease or condition resulting in death) /Medical Idiopathic Thrombocytopenic Purpura Due to (or as a consequence of): Examiner Sequentially list conditions i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine MEDICAL EXAMINER certificate be executed CERTIFICATION APPROVED BY attending physician and burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant requires that the death 3 □ Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the ö Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform The certificate Vita To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes -2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P o After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f deat 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my onlines, death accurred at it. within 24 hours a 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an 00066123

State

Registrar

(1927) OLIVE FREDTOICE, My -21702

f person who completed cause of death (Item 23a) (Type, Print)

32. Registraf's Signature

BOCARUM MO

2008

LAYEEN

31. Date filed (Month, Day, Year)

			Pleas	e Type or Pri						-		gible.			
		For					artment of F			lental Hy	giene				
				26perMD FCHI	KS 3	3/2 1/9	giticate of	Death	· · · · · ·		Reg. No.	008	10/84		
Physici	an	Decedent's Name								2. Date of De Month	Dav	Year	3. Time of Death		
/Medic					e11		T			March	17,	2008	8:00 A M		
Examin	er	, ,		give street and number)			4b. City, Town, o		of Death			unty of Death ederic			
		5. Social Security N		ne Drive	ie (In vrs. la	ast birthday)	Brunsw:	I.C.K.	24 Hrs.	8. Date of Bir			place (State or Foreign		
Funeral Director		450-26-3		1□M 21XF	84	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Cou	intry)		
The model glasses		Usual Residence of								DCC. TO	, 1720	Lene			
rylan how	_	10a, State	10b. County		10c. City	, Town or Lo							10d. Inside City Limits		
e Ma Ba-f s	cto	Texas	Denton			Car	rollton						1 XYes 2 No		
or 2	Funeral Director	10e. Street and Nur					10f. Zip Code					of What Cou			
s 23a	ra	3133 Wi	ndsor Ro					007				d Stat			
item item ner n	ű,	11. Marital Status 1 ☐ Never Marri	iod 2 Marrio	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🛣		5. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexica	ngin? (Spe in, Puerto	Rican, etc.)	14.	Black, White			
ırs af	by F	3 X Widowed		If Yes, Give Year or Dates:	110		1 ☐ Yes 2 X No	Specify.	:		Sp	√hite			
2 hou	ted		15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation			16b. Kind o	of Business/Industry				
hin 7 e. an "n Medi	ple	Elementary/Seco		grade completed) College (1-4or !	5+)	life.	kind of work done DO NOT use retired	auring mos d)	st of work	ing					
ed will ygien er th	Completed			+2		Но	memaker					Own I	Home		
be file tal Hy d oth	Be	17. Father's Name	`			18. Moth	_	First, Middle,		•					
ould I Men arke	은	Sydne		Bergerson					<u>-</u>	pal Ha		nnis			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.		19a. Informant's Na			r		ng Address <i>(Street</i>								
1 and Health Sm 27 ther t		Sherrie Orvis / Daughter 8 Jennifer Lynne Dr., Brunswick, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20c.													
ages nt of l		1 ☐ Burial 2]	Cremation 3	3 □Removal from State	CE	emetery, crei	matory or other plac	i.				-			
artme ortant injury		4 Donation 5 Other (Specify) Stauffer Crematory 3/19/2008 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home													
permi Depar Impor any ir		107N	trail	tail	100								MD 21702		
100		23 Part1. Enter the	he di as a, o c	complications that couse nly one cause on each in	he cath	. Do not ent	-	_					Approximate		
Physician		Immirate Cause ((Final	nly one cause on each if	he.	1	(m) 12		6. 00	. 14/1	1 000	10. +	Interval Between Onset and Death		
/Medical		disease or condition resulting in death)	n	a. Due V (r as	a consequ	ence of):	1010, 0	enes	neovo	1	e acce	and Di	74		
Examiner		snock, or heart failure. List only one cause on each me. Immunicate Cause (Final disease or condition resulting in death) a. /// N. // Death of the modified													
p ±	ner	Sequentially list confidence if any, leading to imcause. Enter Under Cause (Disease or	nmediate erlying	ue to or as	a consequ	strice of):	7								
executed an and rial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	5	· Seize	we	ė.							yes.		
be excian a		Tooding in dodn'y i		d. Perip	a consequ	ence of):	VACA:1/1	i Va 1	Vino	11 -12		i	1 100		
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burat-transit	Physician/Medical			d. Peup	ner	all p	MJE CLUE	6 61	150	1730		93			
certifi iding se as	/Me	IF FEMALE:		23c. If yes, outcome			224	Date of deli	deliven						
atter for u	ciar	in the past 12	months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death 3	□Ectopic pregnancy □ Other (specify)	у			23d. Date of delivery Month Day Year				
the d y the ached	ysi	1 □ Yes 2] 9 □ Unknown													
s that ned b	by PI	Part II. Other signif	ficant condition	23e. Did t	e. Did tobacco use contribute to the cause of death?										
quire en sig uld b	pe pe	DSTOA	Atori,	45, DEP	10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @ Unknown									
aw re	Completed	HISTORY	of Cer	reprovasce		24a. Was		4b. Were aut	topsy findings available						
The tate had age.	m _O	autopsy performed? 1□ Yes 2											ompletion of cause of		
stan: ertifica ctor, I	Be C	25. Was case refer examiner?	red to medical					26. Plac	e of Deat	h (Check only o		1 ∐ Yes			
hysic his ce il dire	10	1 ☐ Yes 2		Hospital: 1 ☐ Inpatie		ER/Outpatier			ursing Ho	me - 5 Mesi	denos- 6 🖺	ther (Spec	Daughter's Residence		
ing P	.: ::	 Manner of Deat 1 Natural 	h 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wor			28d. Describe	how injury o	ccurred			
ttend Jeath stor:	cat	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	t be 200 Place of ini	um. At hor	me form et	M 1 □ reet, factory, office	Yes 2□		Oof Lagation /	Ctroot and M	and a second	val Playta Alymphay		
after on Direct in by	Certification:	4 ☐ Homicide	determin	building, et	c. (Specify)	eet, factory, office			City or To		uniber or nu	ral Route Number,		
spital ours neral		29a. Certifier	1 Certifying	Physician: To the best	of my knov	vledge, deat	h occurred at the ti	me, date a	nd place,	and due to the	cause(s) and	d manner as	stated.		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(Check only one)	2 ☐ Medical E	xaminer: On the basis of and manner st		ion and/or in	vestigation, in my o	opinion, de	ath occur	red at the time,	date and pla	ace, and due	to the cause(s)		
To the within To the comp	Me	29b. Signature and	title of certifier	10:11	. 11	nA	29c. Licens	e number	7//	0	29d. Date si	igned (Month			
- ^		> cel	len	reiler	1-11	10	100	4	14,	7	3.		2008		
20		30. Name and addr	ress of person w	ho completed cause of	leath (Item	23a) (Type,		1	1	1		CK, 1.	10 /		
-01		31. Date filed (Mon	th, Day, Year	32. Registr	ar's Signat	ure H	DUSE A	VC,	0-1	TRO	DOL	Cic, 1	Md 21701		
Sta Registr	1	or, bate med (MOII		2 1 2008 •	ar a digital	A.	Laster								
MH 17 Rev 1/20	- 1		mrtt.	2000		100	57								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Maryland	l / Depa	artment	of H	ealth a		lental Hy	giene	0.00	1070[
			1 - State Registrar			Ce	rtificate	of E	Death			Rag. No.	UUU	10/00			
	Physici	an	Decedent's Name (First, Middle								2. Date of Dea Month	Day	Year	3. Time of Death			
	/Medic	al		May Broadw			14h Cib. T		Location	f Dooth	03	24	2008 County of Deat	10:55 A ^M			
	Examin	ier	4a. Facility Name (If not institution			Four		ık1ar		n Deam		1	Garret				
	Funeral		Garrett Co. Met 5. Social Security Number		'. Age (In yrs. Ia:	st birthday)	If Under 1	1 Year	If Under		8. Date of Birth	h		hplace (State or Foreign buntry)			
ı	Director		233-62-9824	1□M 2⋤F	67	Yrs.	Months	Days	Hours	Min.	(Month, Da)	, rear) 1941		cvland			
	pu ,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits				
	aryla shov	5					Kalion							1 ☐ Yes 2 ☑ No			
	the N	Director	MD Garre 10e. Street and Number	ett	Swar	nton	10f. Zip (Code				10a. Citiza	en of What Co	ountry?			
	with Se or	ă	391 Broadwater	Tano				561					USA	, .			
	ms 2;	Funeral	11. Marital Status	12. Was Deced	ecify Yes or No- Rican, etc.)	10	4. Race - Ame	nericen Indian,									
9	after or ite		1 ☐ Never Married 2 🔀 Marr	ied 1 Tes :	2 ₩ No	i	it Yes, speci 1 ☐ Yes 2		specify:	, Puerto	Hican, etc.)			ack, White, etc.			
933	d within 72 hours after death with the Maryland jiene. r than "naturel", or Items 23e or 28e-f show the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Da			10 105 2	. 54 NO	Specify.				White				
5-("natu	Completed	15. Deceden (Specify only higher	t's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use	done di	uring most	t of worki	ing	16b. Kin	d of Business/	Industry			
12	within ene. than *	E G	Elementary/Secondary (0-12) 7th	College (1-	4or 5+)		sewif					Hon	20				
9	Hyg Hyg sh,	0	17. Father's Name (First, Middle,	Last)		1100	ISEWII		18. Mothe	r's Name	(First, Middle,						
lan	D & & O	To B	Ray G. Love						Mary	y V1:	rginia l	Moats	3				
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	i Route Numbe	r, City or	Town, State, 2	Zip Code)			
	1 and 2 Health a tem 27 is		Paul W. Broadw	ater/ Hush	-				Lane		wanton,						
ore	8 7 = 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ∏Removal from S	l cor	nce of Dispo metery, crea	sition (Name matory or oth	e of her place)		Date	20c. Loc	ation - City or	Town, State			
Ë	nit. Pages artment of ortant: If it injury or o		`4 ☐ Donation 5 ☐ Other (S	(pecify)			er Fan				/08	Swan	ton, M	aryland			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Lioning			2. Name and 2. Sout			016	wart Fu eet,Oak	nera land	1 Home , MD 2	1550			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death.									Approximate Interval Between			
No.	Physician	6.1	Immediate Cause (Final diseasa or condition	bila	toral	W. On	2 04	1011	man	10	-intl	wen	vza	Onset and Death			
1	/Medical Examiner		resulting in death)	Due to (c	r as a conseque	ence of):	1				V		0	2			
	Cxammer	_	Sequentially list conditions,	b. 1 mm	100	ty								3 years			
	ted	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	due to (d	r as a conseque	ence on:	201							Wears			
	be executed sician and burial-transit	Exami	that initiated events resulting in death) Last	c. Due to (c	r as a conseque	ence of):	774							700.			
760,	ite be ex iysician ne burial	cal		L a													
89	tificat ng phy as th		.==														
Вох	th cer lendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnand		Ectopic pre	anancy				23	3d. Date of del	ivery Day Year			
П	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregna 9☐ Unknov	nt at time of dea		Other (spe						MOITH	Day 10ai			
P.O.	hat th d by detach		Part II. Other significant condition	ons contribute a to dea	oth but not result	ting in the u	nderlying ca	usa diva	n in Part I		23e, Did to	bacco us	e contribute to	the cause of death?			
Vital Records,	signed of be del	d by	Din hotos	emo 11_			,	3			1 🗆 Y		/	obably 4 Unknown			
Sor	w requir been s should	Completed	— (CUC) —	112			-				24a. Was	an l	24b. Were at	utopsy findings available			
Re	The law cate has page 2 s	щ									autop perfor	sy megl?	prior to death?	completion of cause of			
ţa		a)	25. Was case referred to medica						26. Place	of Death	1 Yes	20 No	1 LI Yes	2 No			
<u> </u>	Physicien: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	patient 2 🗆 E	R/Outpatier	nt 3□ DOA	Othe	-		me 5□Resid		☐Other (Spe	cify)			
0			27. Manner of Death ↑ Matural 5 □ Pendin	28a. Da e of (Month	Injury 2 Day Year)	28b. Time o Injury	f 28	lc. Injury Work	at ?		28d. Describe h	ow injury	occurred				
<u> </u>	Attending r death. sctor: After by the fune	atic	2 Accident investi	gation			М	1 🗆 Y	'es 2 □ l	-							
Division of	P # in in in	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place (of Injury - At hom g, etc. (Specify)	ne, farm, str	eet, factory,	office			28f. Location (S City or Tow		Number or Ru	ural Route Number,			
	To the Hospital or Attenswithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C		g Physician: To the t Examiner: On the bas and manne	is of examination												
	To the within To the compl	Me	29b. Signature and title of certifie	r 1 1	/ .			License				_	signed (Mont	/			
			Margan	AUX	aux	M		D	265	50		3-	25-2	BOOL			
		4	30. Name and address of person	who completed cause	of death (Item 2	23a) (Typé,	Print)	# 1	in O.	1140 10	10	alio.	a D 1	2008 1d 21550			
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	ire 7	urve	7 L V	ugu	J		nuca	no n				
	Registr		MAP 2	8 2008	desert to	J. A	good.										

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any iniportant: If them 27 Is marked of other than "natural", or items 23a or 28a-f show any initial or with the Marylesial Examiner must be notified at Baltimore, Maryland 21215-0036

Direc

Physici /Medic

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director mane 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Reg

		For State		S	tate of	Marylan	-	artment of h		d Men	ıtal Hy			(1) (0)		706	
		Registrar 1. Decedent's Name	(Eiret Middle	a laeth			CE	rtificate of	Dealli	2 [Date of De	Reg. No.	20	08	3. Time of	Death Death	
Physicia	ın			anin							Month	Day Year					
/Medic Examin		Susan An			t and numb	er)		4b. City, Town, o	or Location of De		March 18, 2008				2.50	, a	
EXAMIN	51	18604 Her						Brookevi	.11e			Мо	ntgo	mery	7		
Funeral		5. Social Security Nu		6. Sex	7.	Age (In yrs.	last birthday		If Under 24 H	in, 8. [Date of Bi	rth ay, Year)		9. Birthp	place (State o	r Foreign	
Director		047-52-24		1 □ M	214,5		0 Yrs.	Morking Buye	Troute III	Ma	y 12	, 195	7 F		Íslar	ıd	
8	ŀ	Usual Residence of I	Decedent 10b. County			10c. Cit	y, Town or L	ocation						1	0d. Inside Cit	ty Limits	
f sho	ō	MD	Montgo			Pros	kevil	1.							1 □Yes	2 🕅 No	
notif	Director	10e. Street and Num	10f. Zip Code				10g. Citizen of What Country?										
st be		18604 Her	itage	Hills	Road	l		20833				USA					
er mu	Funeral	11, Marital Status		12.1		ent Ever in U	.S. 13	Was Decedent of H	Hispanic Origin?	(Specify Jerto Rica	Yes or Nan. etc.)	0- 1		e - Americ k, White,	an Indian,		
or ite		1 Never Marrie		ried	I ☐ Yes 2 f Yes, Give	X No		1 ☐ Yes 2 X No			, 0.0.,						
ural"; Il Exa	d by	3 ☐ Widowed 4			rear or Date	es:	I don Don			16b. Kind o			Whit				
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othe orthe	BeC	17. Father's Name (/	First, Middle,	Last)					18. Mother's N	Name (Fi	rst, Middle	e, Maiden	Surnam	ie)			
Vienta irked	10 E	Samuel Gr	ills						Rose Ab	osso							
and I		19a. Informant's Nar	me/Relations	hip (Type.	Print)		19b. Mai	ing Address (Street	t and Number or	r Rural Ro	oute Numi	ber, City or	r Town,	State, Zip	Code)		
m 27		Brian G.		n/husl	and	Took I		4 Heritag	<u>e Hills</u>		d Bro					}	
if of H		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State															
rtmen rtant: njury		4 Donation 5 Other (Specify) Chesapeake Crematory 03/19/08 Beltsville, MD															
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ligensee Going Home Cremation Service P.O. Box 784 Coing Home Cremation Service P.O. Box 784 Reverly I Hockrotte P.A. Clarksville MD 21029															
TS-128		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														e	
		Shock, or heart fallure. List only one cause on each line. Immediate Cause (Final														ween Death	
nysician Medical		disease or condition resulting in death)	1	a		stive F		Failure						-	5 year	S	
xaminer					,			ve Lung D	licasca						5 vear	*s	
# # P	ner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in	iditions, mediate Iving) "	Due to (or	r as a conseq	uence of):	ve nune n	1.00.000						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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physi s the t	dical	<u>0</u>															
nding Ise at	/Me	IF FEMALE: 23b. Was decedent	pregnant	23c.	If yes, outco			23d. Date of delivery			ery						
d for u	Physician/M	in the past 12 r	months?		1□Live bir 4□Pregna	□Ectopic pregnand □ Other (specify) _						Month Day Year					
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as be	Completed									_	24a. Wa	opsv	F	prior to co	opsy findings impletion of c		
page	Con										per 1□ Yes	formed? 2X No	1	death? I∐Yes	2 □ No		
ector,	Be (25. Was case referre	ed to medica	Hosp	ital:			Ot	26. Place of								
this all dir	P.	1 ☐ Yes 2 X 1			1 ☐ Ing		ER/Outpation 28b. Time	JIK 0 2011	her: 4 Nursin			sidence 6 how injur			fy)		
h. Affer funei	tion	1 X Natural 2 ☐ Accident	5 Pendir investi	ng		Day Year)	Injury	Wo	ork?]Yes 2 □ No	200.	. Describe	now injur	y occurr				
deat ctor: y the	fica	3 ☐ Suicide	6 Could determ	not be	8e. Place o	f injury - At h g, etc. (Speci	ome, farm, s	treet, factory, office		28f.	8f. Location (Street and Number or Rural Route Number,					nber,	
after I Dire	Certification:	4 Homicide	4010111				City or 1	own, State	, State)								
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical (sis of examina		ath occurred at the t investigation, in my								5)	
within To th comp	Me	29b. Signature and title of certifier						29c. Licen	se number			29d. Dat	e signe	d (Month,	Day, Year)		
		> Jan	dy	140				D187	26			Marc	h 18	8, 20	800		
2		30. Name and address	ess of person choenge	who comp	eted cause	of death (Iter	n 23a) (Type Prince	Philip I	or. #T-1	.0 01	ney,	MD 2	0832	2			
Sta		31. Date filed (Mont			497	gistrar's Sign		-									
Registr	- 6	M	AR 1	9 2008	Be	State .	B. F.	berte									
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				State of Ma	aryland /	•	iment of r <i>ficate of</i>			gierie Reg. No.?	8	10787		
	Dhuaisi	25	1. Decedent's Name (First, Middle, Last)				_		2. Dete of Dee		Year	3. Time of Deeth		
- Congress	Physici /Medi		HELEN JO	HANNA	_CR	DUS			03-	12-20	800	1010 AM		
4	Examir	ner	4e Fecility Name (If not institution, give s Glade Valley Nursi		ah Ce	nter		4b. City, Town, or I Walkersv		4c. County o				
4	Funeral		5. Sociel Security Number 6. Sex	7. Age	e (In yrs. last	birthdey)	If Under 1 Year	If Under 24 Hrs.	9 Date of Birth			e (State or Foreign		
	Director		220 – 28 – 7768	M 2√ F	82	Yrs.	Months Days	Hours Min.	May 9,	1925	Polano	e (State or Foreign d		
	pue *	•	Usuel Residence of Decedent 10e. State 10b. County		10c. City. To	own or Loca	tion				10d.	. Inside City Limits		
	Menylic f sho	jo	Maryland Frederick			rsvil						1√2 Yes 2□No		
28a-1		Director	10e. Street and Number	.	Walke	.10711	10f. Zip Code			10g. Citizen of Wi	nat Country	?		
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Haath and Mantal Hygiena. Department of Haath and Mantal Hygiena. Important: If tan 27 Is marked other than "natural", or Hems 23a or 28a-1 show may Injury or other traumatic event, the Medical Examiner must be notified at	th wit	al D	56 West Frederick S	Street			217	93		U.	S.A.			
	urs after dea al', or flems xaminer m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Detes:			s Decedent of Hes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- American , White, etc White	.		
21215-0020	within 72 hor ana. than "natura	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5	+)		nt's Usuat Occup nd of work done NOT use retire	oation during most of wor d)	king	16b. Kind of Business/Industry Restaurant				
	Hygie Hygie other		17. Father's Name (First, Middle, Last)		1	,,,	101033	18. Mother's Nan	e (First, Middle, Maiden Sumame)					
<u>lan</u>	rould be filed withing Mantal Hygiena. Terked other than netic evant, the Mantal Mant	To Be	Johann Wrarczak		ie Unl	known								
Maryland	and 2 should saith and Man of 27 is marke for traumatic		19a. Informant's Name/Relationship (Type Raymond Crouse, Jr.					and Number or Ru Jeffersor				ode)		
Baltimore,	Pages 1 a nent of Ha int: If Itam iry or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	moval from State			ion (Neme of tory or other pla Mem. Ga		Date 3/14/08]	20c. Location - C	-			
Balti	parmit. Page Department of Important: If any Injury or once.		21. Signature of Fignaral Service License	Filest	P			DATLEY & MARKET S						
	į.		23a. Part. Enter the diseese, or complice shock, or heart failure. List only on	ations that caused cause on each tin	the death. D						Ap	pproximate iterval Between		
in the second	Physician /Medical Examiner		Immediate Cause (Finat disease or condition resulting in death) a.	Cn	rge	stu	He	or to	silve		ز	flours		
Н	ed sit	Examiner	Due (o (br as a consequence of): Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):											
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68760,	ysicia ysicia	edicai	Cause (Disease or injury that initiated events											
	ing ph		Due to (or as a consequence of):											
Box	aath cert attending for use	lan	0.											
P.O.	that tha daath cer ed by the attendin datached for use	Physician/M	Part II. Other significant conditions cont	ributing to death bu	at not resulting	g in the und	erlying cause gi	ven in Part I.	23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
	s that ined by data	by Pr	Dementa		101	/es 2/□ No	3 Probat	Ny 4 Olikhown						
of Vital Records,	The law requires that the death cert ata has been signed by the attending page 2 should be datached for use	Completed b								an autopsy med?	availa	autopsy findings able prior to pletion of cause ath?		
R	hysician: Tha law nis certificata has I director, page 2	E O							1014	us aLNu	1 🗆 Y	res 2□ No		
/ita		Be	25. Was case referred to medical examiner?						th (Check only o	ne)				
of \	Physician: this certific ral director,	ျ	1 ☐ Yes 2 Z No	ospital: 1 ☐ Inpatie		Outpatient	3LI DOA			lence 6 □Othe				
no	ding F h. After funer	tlon	27. Manner of Deeth 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injur (Month, Day	Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2□No	200. Describe i	iow injury occurre	ď			
Division	or Attano after deat Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							Street and Numbe m, State)	r or Rurel A	loute Number,		
_	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edicai C	29a. Certifier (Check only one) 2 Indical Examin	cian: To the best of er: On the basis of and manner sta	exemination									
	To th To th comp	X	29b. Signature and title of certifier				29c. Licens	se number	,	29d. Date signed	(Month, Da			
			Aus				D	2651	0	MARC	<u> </u>	12 2008		
	3		Ao. Name and address of person who cor	pleted cause of de	eeth (Item 23	e) (Type, Pr	EY AVE	FOR	PENJ	CK N	D :	21702		
*	Sta Registr	- 6	31. Date filed (Month, Day, Year) MAR 1	32. Registra	ar's ignature	· M	Source		,	/				

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		For State Registrar		State	of Ma	arylan		epartment of Certificate of			lental Hy	/gien Reg. N	0000	2 10	1788
		Necedent's Nam	ne (First, Middle,	, Last)				oor imouto or	Dou.		2. Date of D	eath	- L - U - U - L	3. Time	of Death
Physician /Medica		Martin			Н.			Clair			March	13,	² 2008 Year	5:3	35 A м
Examine	r	4a. Facility Name (/			umber)			4b. City, Town,		on of Death		j	c. County of De		
Funeral		Tate Ho. 5. Social Security N		6. Sex	7. Ag	e (In yrs.	last birth		r If Und	ler 24 Hrs.	8. Date of B	irth	Anne Arı	irthplace (State or Foreign Country)	
Director		202-05-5632 8/ Ns. April 13.1920 Per											nnsy1va	ania	
m +i		Usual Residence of 10a. State	f Decedent 10b. County			10c. City	y, Town	or Location			*			10d. Inside	City Limits
a-f she	֓֞֝֓֞֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Maryland Anne Arundel Annapolis										1 □ Yes 2 🗓			
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commission by Europea Director		10e. Street and Number 10f. Zip Code										10g. C	Citizen of What C	-	
s 23a nust b	a .	2542 Miss	ion Hil			Free in 11	0		21401	0.1-1-0.40-			US.	American Indian, Vhite, etc. White	
r item	runerai	 Marital Status Never Marr 	ried 2∐ Marrie		Forces?		S.	13. Was Decedent of If Yes, specify Cu			Rican, etc.)	0-	Black, Wh		
Exan	2	3 🔀 Widowed	4 Divorced	If Yes, 0 Year or	aive Dates:			1 ☐ Yes 2 No	Speci	ify:			Specify: W		
"natu edical	919	(Spec	15. Decedent' cify only highes	s Education t grade completed	1)		16a, [Decedent's Usual Occu Give kind of work done life. DO NOT use retin	pation during m	ost of worki	ng	16b.	Kind of Busines	s/Industry	
the Man	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5	5+)		Owner	50)			Mec	hanical	Engine	eering
d other		17. Father's Name (First, Middle, Last)							18. Mo	ther's Name	(First, Middle	e, Maide	en Surname)		
arked atic e	2	Frank Cla					1			nces I					
7 Is n		19a. Informant's Na Jeffrey C						Mailing Address <i>(Stree</i> 13 Independ							20003
Item 2 other	-	20a. Method of Disp				20b. P		Disposition (Name of crematory or other pl			ate		Location - City of		
iry or			©Cremation 5 ☐ Other (Sp	3 □Removal from ecify)	n State			crematory or other pi Crematory	ace)	3-14-	-08	Edg	ewater,	Maryla	and
ny inju		21. Signature of F	peral Service L	icensee				22. Name and Addi George P.	ess of Fac	cility S Fune	eral Ho	ome.	P.A.		
드통리	1	One Down Carry	up /!/	W.		1 41 41	. Da a	12973 20101	ions	<u>ısıan</u>	ı Ku.,	Edg	ewater,	MD 210	
		23a. Part1. Enf r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or capalities)													nate Between nd Death
sician ledical		disease or condition resulting in death) a. Due to (or at a consequence of):													
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sit sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Usedae or injury.													
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				d											
etached for use as the bu		IE EEMAI E											-		
for use as	la l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy											23d. Date of delivery Month Day Year		
iched veic	331	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown										,			
ld be detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											to the cause o	of death?	
should t		$(\mathcal{N}, \mathcal{F})$	sot 1	5 chami	- u) / th	20	ngrene	-		1	Yes	8 1 No 3 □ I	Probably 4	Unknown
page 2 should	1	autopsy prio										prior to	autopsy finding completion o	gs available of cause of	
irector, page 2 s		performed? death? 1													
director	ב	examiner?	<i>(</i> ************************************	Hospital: 1] Inpatie	ent 2 🗆	ER/Out	patient 3 DOA	her:		ne 5□ Bes		6 Øother (Sp	acity Ason	de resid
funeral director,		27. Manner of Death	th 5 Pending	28a. Dat		ry	28b. Ti				28d. Describe			cony page	, ,
the funeral di		2 Accident 3 Suicide	investiga 6 ☐ Could no	ation of he					Yes 2						
led in by the funer.		4 ☐ Homicide	determin	and Zoe. Place	ding, et	c. (Specif)	me, tarr /)	n, street, factory, office		2	28f. Location City or To		and Number or F ite)	Rural Route N	lumber,
completely filled in by the f		29a. Certifier (Check only one)	Certifying	examiner: On the	ne best basis of nner sta	f examina	wledge, tion and	death occurred at the /or investigation, in my	time, date opinion, d	and place, a death occurr	and due to the	e cause e, date a	(s) and manner a and place, and de	as stated. ue to the caus	se(s)
Comp		29b. Signature and	title of certifier	() m	-0			29c. Licer	se numbe	//		29d. D	Pate signed (Mor	oth, Day, Year	7)
4		30. Name and addr	ress of person w	vho completed cau		eath (Item		ype, Print) Solmus I	3 kmd	0 20	Anna	noli	SMD	2-15	101
													/		
State Registrar		31. Date filed (Mon	th, Day, Year)	2008 32	Registra	ar's Signa	ture	down.				-			/

		State of Maryland / De	partment of Health an ertificate of Death	nd Menta	l Hygiei Reg.	2001	8 10789
		Registrar 1. Decedent's Name (First, Middle, Last)	ortinoato or Boatin		of Death	NO.	3. Time of Death
Physici		Colleen Cantwell Dea	n	Mor		Day Year 2008	9:55 P ^M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D			4c. County of Dea	
LXaiiiii		9054 Albaugh Road	New Windso	r		Freder	ick
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24	Hrs. 8 Date	of Birth	9 Bir	thplace (State or Foreign
Director		212-98-0377 1 M 2 M F 26 Yrs	Months Days Hours		nth, Day, Ye • 31,		shington, DC
pu ,		Usual Residence of Decedent	1				
arylaı show dat	_	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ne Ma 8a-f	Director	7	Windsor				
vith the	Dİ	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	ountry?
s 23a oust	Funeral	9054 Albaugh Road	21776	0.10		United	
er de item: ner n	nu	Armed Forces?	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 	n? (Specity Ye: Puerto Rican, e	s or No- etc.)	14. Race - Ame Black, Whit	
rs aft	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			Specify: W	Mite
tural Est	ed		cedent's Usual Occupation		16b	. Kind of Business	/Industry
in 72 n "na fedic	plet	(Specify only highest grade completed) (G	ve kind of work done during most of . DO NOT use retired)	f working			,
with jene	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	None			None	
othe file	Be C	17. Father's Name (First, Middle, Last)	18. Mother's	Name (First,	Middle, Maid	den Surname)	
I and yild in a first 12-0000 at 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the yildine. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To B	Lawrence B. Dean	Beve	rly Sha	aw		
shot smd N		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number of			ity or Town, State,	Zip Code)
and 2 alth alth alth alth alth alth alth alth		Lawrence B. Dean / Father 9054	Albaugh Road	New Wi	ndsor,	Marylan	d 21776
as 1 se of He item		cometery (position (Name of	Date	20c	. Location - City or	
Page nent int: If		1 Burial 2 Storemation 3 Hemoval from State	k Crematory	arch 12 2008	' F1	rederick.	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility				
2 age # 8			1621 Opossumtown	Pike	Frede	rick, Mar	yland 21702
		23a. Part1. Enter the dis ase or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as ca	ardiac or respir	atory arrest,		Approximate Interval Between
Physician	8 0	Immediate Cause (Final disease or condition	715				Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):			-		- C / C 3
Examiner		Sequentially list conditions b. ISCHEMIC	Bown				WKS
p ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last C					
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The law requires that the death certific the law requires that the death certific are has been signed by the attending page 2 should be detached for use as large.	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy				001.01.61	
atten for u	ian	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	Day Year
he de	ysic	1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	Other (specify)				
w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	236	e. Did tobaco	co use contribute to	the cause of death?
sign d be	db				1 ☐ Yes	2 ⊡1 √No 3□P	robably 4 □Unknown
v requ	ete				14/	24. 14	
has has	Completed			248	 Was an autopsy performed 	prior to	utopsy findings available completion of cause of
ician: The l					Yes 2	No 1 ☐ Yes	2 □ No
nysician: nis certifica director, p	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	f Death (Check			
_ ज ≑ ज (. To	1	ient 3 DOA 4 Nursii			e 6 Other (Speniury occurred	ecify)
and the line	lion	1 Natural 5 Pending (Month, Day Year) Injur			SCIIDE HOW I	rijury occurred	
deat deat ctor: y the	iica	3 Suicide 6 Could not be 28e, Place of injury - At home, farm.			ation (Stree	t and Number or R	ural Route Number,
lor A affer Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,,,		or Town, S.		arar riode rumbol,
spita nours neral y filled		29a. Certifier 1- Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and p	place, and due	to the caus	e(s) and manner a	s stated.
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death	occurred at th	e time, date	and place, and du	e to the cause(s)
Veit To Con To	M	29b. Signature and title of certifier	29c. License number		29d.	Date signed (Mon.	
		MMD	D3217	(3/12/	08
3		30. Name and address of person who completed cause of death (Item 23a) (Type					
		RICHARD L. GOUGH PO PO	BOX 328 WAL	LKCRSU	THE	mo 2	1793
Sta Registr		31. Date filed (Month, Day, Year) AR 1 3 32. Registrar's gnature	B. Aports				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Thomas William Foyle 2008 March 23 A^{M} 12:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22820 Maple Road Lexington Park St. Mary's 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 XM 2 ☐ F 199-36-6149 09/05/1944 Director 63 Pennsylvania Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygene.

other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director Maryland | St. Mary's Lexington Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or ms 23a 22820 Maple Road 20653 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 ⊠Yes 2 No 1968-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced Year or Dates 1972 Completed than "natur the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Defense Contractor permit. Pages 1 and 2 sho lid be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Foyle 2 Elisabeth Lynn Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Foyle / Wife 22820 Maple Road Lexington Park, Maryland 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 03/24/2008 Charlotte Hall, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s director 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No death. 2 ☐ Accident hours after death Ineral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral D Hospital

> State Registrar

completely

Medical

29a. Certifier

(Check only one)

30. Name and address

Jennifer

31. Date filed (Month. Da

29b. Signature and title of certifier

Schmidt,

person who completed cause of death (Item 23a) (Type, Print)

r's Signature

32. Regis

D.O.

2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

40900 Merchants Lane, Leonardtown, MD

29c. License number H00 557 5 1

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	Maryland /	•	ent of He		Mental Hy	giene Reg. No.	08 10791
	Physici /Medic		1. Decedent's Name (First, Midd	fle, Last)	F	iKE			2. Date of De Month May	Day	3. Time of Death
	Examin	er	4a. Facility Name (If not institution Garrett County	Memorial Hos	spital		City, Town, or I				rett
	Funeral Director		5. Social Security Number 218–40–3245 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	Age (In yrs. last b	Yrs. Mor		Hours Mi		ıv, Year)	Birthplace (State or Foreign Country) Maryland
	se-f show	ctor	10a. State 10b. Count WV Prest			wn or Location	a				10d. Inside City Limits 1 X Yes 2 □ No
	ith with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 207 Aurora Aver	nue			f. Zip Code 26764			10g. Citizen of 1	
036	n 72 hours after death with the Maryland "neturel", or Iteme 23e or 28e-f ehow edicel Evantiner must be notillied at	þ	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give	s? X No		ecedent of His specify Cuban es 2 No	panic Origin? , Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Specif	ce - American Indian, ck, White, etc. fy: White
21215-0036	within 72 ene. than "ne	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	ent's Education lest grade completed) College (1-40	or 5+)	a. Decedent's (Give kind of life. DO No	Usual Occupat of work done du OT use retired)	tion uring most of v	vorking	16b. Kind of B	dusiness/Industry
Maryland 2	be filed stal Hyg od othe event,	Be	17. Father's Name (First, Middle Norris Fike), Last)				Mary	lame (First, Middle VanSick	le	
	1 and 2 sh Health and em 27 le m ther traum		19a. Informant's Name/Relation Lisa M. Ditmore 20a. Method of Disposition		20	_	ra Ave	., Aprt	Rural Route Numb 8, Ter	ra Alta,	
Baltimore,	Page nent o ant: ff ury or		1 🔀 Burial 2 Cremation 4 Donation 5 Other 21. Signature of Fugeral Service	(Specify)	10 _	e Cemet		Mar	ch 28,		sville, MD
Ba	Departi Departi Importi eny Inji		D. Lyn	I Jeuna	end the death. Di	New 179	man Fur Mille	neral H Stree	lomes, P.	sville,	MD 21536
	Physician /Medical Examiner per prigitalitiansi	ı Examiner	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Scyl Due to (or a	as a consequence ANIA as a consequence ANA as a consequence ANA as a consequence	hnzi	in o net t and E	(ER)	diac ,	tones ASE	Interval Between Onset and Death
.O. Box 68760	death certificate e attending phy id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal dea at time of death		pic pregnancy ar (specify)				ate of delivery onth Day Year
Δ.	signed be de	٥	Part II. Other significant condi	tions contributing to death	n but not resulting	g in the underly	ring cause give	n in Part I.		tobacco use con Yes 2 ☐ No	atribute to the cause of death? 3 Probably 4 Abriknown
Il Records,		Completed							24a. Was auto peri 1 Yes	opsy ormed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital	Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	atient 2 ER/	Outpatient 3	DOA Othe	r. 4 🗆 Nursin	Death <i>(Check</i> on <i>ly</i> g Home 5 Res		her (Specify)
Division o	ath. r: After	Certification:	3 Suicide 6 Coul	stigation d not be 28e. Place of	Day Year) Injury - At home, etc. (Specify)	o. Time of Injury M farm, street, f		at ? ′es 2 □ No	28f. Location	(Street and Num	rred ber or Rural Route Number,
	Hoepil 14 hour Funer tely fills	Medical Ce	29a. Certifier 1 Certify (Check only 2 Medical	ying Physician: To the be al Examiner: On the basis and manner	s of examination	ige, death occ and/or investig	urred at the tim ation, in my op	e, date and pla inion, death o	ace, and due to the ocurred at the time	cause(s) and m , date and place,	nanner as stated. , and due to the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and little of certif	Jus.		wo	29c. License			29d. Date signed	ed (Month, Day, Year) 2 6 2008
		1	30, Name and address of person	Buczynsk	, lu	(Type, Print)	r, 40	-4 57	· 1 840	TE (26, 2008 Caklandha
	Sta Regist		31. Date filed (Month, Day, Yea	7 2008 32. Region	strar's Signature	Ana	E.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** March 26, 2008 Flovd Elmer Grove 12:40 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Friendsville 1459 Mill Run Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 12, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**☐M 2☐F Maryland 91 **Director** 214-18-0820 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show 27 la marked other than "natural", or Itema 23a or 28a-f shov traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD Garrett Friendsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1459 Mill Run Road 21531 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentai Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Modest Examinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced White WW2 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Clay Plant/Kaiser Ref. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Lloyd J. Grove Mary E. Beckett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1459 Mill Run Road, Friendsville, MD Terry R. Grove/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town State 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Addison Cemetery March 29, * 4 ☐ Donation 5 ☐ Other (Specify) Addison, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Newman Funeral Homes, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician cerebrovascular accident immediate /Medical Due to (or as a consequence of): Examiner cerebrovascular disease years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit the death certificate be executed high blood pressure years Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown N/A signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. osteoarthritis been sig 1 Yes 25 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2₩ No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/26/2008 D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N Fourth Street Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2008 Registrar Markey

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** March 29, 2008 8:47 P. M Lue Hilda Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington *318 Lanafield Circle* Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 79 Director Florida 261-32-8311 Usual Residence of Decedent May 19,1928 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □ ¥es 2 □ No Director Md. Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 318 Lanafield Circle Funeral 21713 U.S.A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grady Hinsey Marie Shiver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerina H. Daugherty (Daughter) 6619 King Rd. Boonsboro, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 2008 4☐Donation 5☐Other (Specify) Hagerstown, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 AUIS Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acyte Myocardial 6 Hrs disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner ATHRO The law requires that the death certificate be executed sec that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) n signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Artery has been sig ge 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes No No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this neral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 31, D44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lappans Rd Boonsbow 20311 MD

State Registrar 31. Date filed (Month, Day, Year)

APR 0 3 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MORTH RCH Day Q, 2 Veat 8 **Physician** E:ESF M Lucille Helen Hartwigsen /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ YF 65 April 20, 1942 Pennsylvania Director 188-32-5800 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be mattled to once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Cecil Perruville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21903 54 Riverview Drive Funeral . Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Bartish Unknown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 54 Riverview Drive, Perryville, Maryland 21903 Jason Dainton (Son-in-law) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 3/25/2008 Darlington, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final MULTIPLE SYSTEMS ORGAN FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CARDIOGENIC SHOCK Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed MITRAL REGURGITATION attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ACUTE ABDOMEN Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▶ No 24a. Was an autopsy certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this Director; After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifie

TIMOTHY LOW

31. Date filed (Month)

MAR 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

2008

DRIVE,

7601 OSLER

32. Resistrar's Signature

29c. License number

D24034

TOWSON,

29d. Date signed (Month, Day, Year)

MARYLAND 21204

			For State Registrar	State o	f Marylan	•	artment of I rtificate of			lent à l		ene 🦳 '	UUU	10730
			Decedent's Name (First, Michael Control of the	ddle, Last)			inrodito or			2. Date	of Death			3. Time of Death
	Physici /Medi		GRACE Z. HO	HOSTER						Month MARCH		Day Year 10 2008		1445 M
	Examir		4a. Facility Name (If not institu		mber)		4b. City, Town,	or Location	of Death	23321022			ity of Death	
			TALBOT HOSP	ICE HOUSE				STON					TALBO	T
į.	Funeral Director		5. Social Security Number 213–05–5619	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date (Mont	of Birth h, Day, 1	Year) 1916	9. Birthp Coun MARY	
	and w		Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
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	the 1 28a-	Director	10e. Street and Number	FALDUE		Sr. MI	10f. Zip Code				10	g. Citizen o	f What Coun	try?
	3a or	Ö	711 RIVERVI	EW TERRACE				21663				USA		
	death ms 2	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Decedent of I	Hispanic Or	igin? (Spe	ecify Yes	or No-	14. R	ace - Americ	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ M 3 12 Widowed 4 □ Divord	If Yes. Giv	2 X No ve		lf Yes, specify Cub 1 ☐ Yes 2 X No			rican, etc	;.)	Spec	lack, White,	
5-0036	2 hot latura Ical E	Completed	15. Deced	dent's Education		16a. Dece	dent's Usual Occu	pation	-4 -64-5		1 1	6b. Kind of	Business/Ind	lustry
215	within 7 iene. than "n	E Pe	Elementary/Secondary (0-12	thest grade completed) 2) College (1)	1-4or 5+)	life.	kind of work done DO NOT use retire	auring mos ed)	st of Worki	ng				
2121	filed withi Hygiene. ther than	5	12	2			MANAGER	1					OK STO	RE
Maryland	be fill htal H id oth even	Be	17. Father's Name (First, Midd							, ,	,	aiden Surna	,	
yla	nould be a Mental narked o natic eve	မ	FREDERICK A			10h Maili	a Address (Ctras					CTH LI		2-1-1
Mai	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relation		MTEGE		ng Address (Street					-		•
	1 and Health tem 27 other tr		PATRICIA K. WO 20a. Method of Disposition	OKIHINGION/	20b. F	Place of Dispo	EN VALLE	i		ate			1 - City or To	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		State		natory or other pla SH CEMET	i	3/17	7/200	R	TOADI	or Ma	RYLAND
Ħ	artme ortan injur		21. Signature of Funeral Servi		441		2. Name and Addre			7200	0	TVALI	E, FR	KILAND
B	permit. Departr Imports any inje		JOHN R	MERC	FRON	\ F	ELLOWS,	HELFE	NBEIN	1 & N	EWNA	M FUN	NERAL I	HOME PA
	W 4 1 4		23a. Part1. Enter the disease shock, or heart failure.	or complications that c	aused the deat	_	00 S. HA	ing, such as	s cardiac d	or respirat	ory arres	st,	21001	Approximate Interval Between
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	/Medical		resulting in death)	a. Due to	(or as a conse	nce of):	ny	VI P	DYV				0	(months
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38760,	cate be executed physician and the burial-transit	dical		d									-	
9		Physician/Me	IF FEMALE:	23c. If yes, out	tcome pf pregna	ancv						034	Date of delive	
Вох	eath atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	oirth 2 ☐ Feta nant at time of c	al death 3	Ectopic pregnand Other (specify)	су					Month	Day Year
P.O.	the d y the	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unkn										
	The law requires that the death certifiate has been signed by the attending agge 2 should be detached for use as	by PI	Part II. Other significant cond	ditions contributing to de	eath but not res	sulting in the u	nderlying cause gi	ven in Part I	l.	23e.	Did toba	acco use co	ntribute to th	e cause of death?
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Records,	aw re Is bee	plet	Congre	tive H	earl	Fail	uve.			24a.	Was an	241	. Were auto	psy findings available
	sician: The law certificate has b irector, page 2 s	Completed								10 1	autopsy perform	ed?	death?	npletion of cause of 2□ No
or Vital	ian: ertifica ctor, p	BeC	25. Was case referred to med examiner?					26. Place	e of Death					
<u>r</u>	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 □] ER/Outpatier	nt 3□ DOA Oti	her: 4□ Nu	ursing Ho	me 5	Residen	nce 6 🟋	ther (Specif	HOSPICE
n o	ding P. After ti		27. Manner of Death 1 Natural 5 ☐ Pen	28a. Date iding (Mon	of Injury th, Day Year)	28b. Time o Injury	Wa			28d. Desc	ribe hov	v injury occ	urred	
Sio	Attending or death. ector: After by the fune	cati	2 ☐ Accident inve	estigation				Yes 2□	-					
Division	or At fiter d Direct in by	Certification:		ermined 28e. Place buildi	of injury - At hing, etc. <i>(Specii</i>	ome, tarm, str fy)	eet, factory, office		2	28f. Locat City o	ion <i>(Stre</i> or Town,	eet and Nur. State)	nber or Rura	I Route Number,
	pital ours a eral I		29a, Certifier 1 Certif	fying Physician: To the	hest of my kno	owledge deat	h occurred at the t	ime date a	nd place	and due t	n the cal	ueo(e) and i	mannor as s	tated
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medic one)	cal Examiner: On the b	asis of examina ner stated.	ation and/or in	vestigation, in my	opinion, de	ath occurr	ed at the	time, da	te and plac	e, and due to	the cause(s)
	To the within To the complete	Me	29b. Signature and title of cert	ifier			29c. Licen	se number			29	d. Date sigr	ned (Month,	Day, Year)
			MACHI	el XIII	red	W	T	147	232	_		031	121	2008
	00		30. Name and address of pers	on who completed caus	se of death (Iter	m 23a) (Type,	Print)	•					-	
ě	0)		Ham S.D.		ND	401	Purdy "	Stree	et i	Ste	101	E	eston.	mD 21601
	Sta		31. Date filed (Month, Day, Ye		istrar's Signa	ature	hack is				-		7	
	Registi	ar	MAK	1 3 2008	CHUR !	N 19	THE PERSON NAMED IN							

DHMH 17 Rev 1/2001

3			For State Registrar 1. Decedent's Name (First, Middle, L		-	Certifica		Death		eg. No.	8.01	3. Time of Death
	sicia		MARTHA GROVE	,					Month MARCH	Day 12	2008	5:50AM M
	ledic amin		4a. Facility Name (If not institution, g			4b. City	, Town, o	or Location of Death			ity of Death	3130111
			WILLIAM HILL GA	ARDENS			EAST				TALBO	r
Fund Direct			5. Social Security Number 6. 295-01-5677 Usual Residence of Decedent	Sex 7. Agr 1 □ M 2 X F	90	Yrs. If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JAN 08,	, _{Year)} 1918	9. Birthpl Coun OH	
rland ow	=		10a. State 10b. County 10c. City, Town or Location									0d. Inside City Limits
Mary a-f sh	Lied a	ţo	IL KAN	č	ST.	CHARLE	S					1 XYes 2 □ No
th the	e not	Director	10e. Street and Number	-			p Code		1	0g. Citizen o	f What Coun	try?
ath wi	nst b	ral	4N511 PLEASANT	_				60175		US		
(1 Z 1 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show	xaminer n	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Y		13. Was Dece If Yes, spe 1 ☐ Yes		dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - America ack, White, e	
2-C	Ica	Completed	15. Decedent's l (Specify only highest g	Education	16a.	Decedent's Usu	ual Occup	nation	ina	16b. Kind of	Business/Ind	lustry
iffin Je	event, the Medical	apple .	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of work d)	ing			
led w	<u>بر</u>		12 17. Father's Name (First, Middle, Las	2		SECRET	ARY	18. Mother's Name	/First Middle I		OOL SY	STEM
and d be f antal H	eve	Be	ROY H. GROVE						CHE M. R		arrie)	
aryla should I ind Men	mat E	2	19a. Informant's Name/Relationship	(Type. Print)	19b.	. Mailing Addres	s (Street	and Number or Rura			n. State. Zip	Code)
MG 2 alth a 27 is	r tra		HARRY M. HECKATHO	ORN III/SON	r :	ро вох	125 (CHURCH CRI	EEK. MD	21622		,
or Hea	r othe		20a. Method of Disposition	·	20b. Place of	Disposition (Na	me of	; (20c. Location	- City or To	wn, State
Daltimor Dermit. Pages Department of mportant: If its	any injury or other traumatic once.		1 ☐ Burial 2 X remation 3 4 ☐ Donation 5 ☐ Other (<i>Spec</i>					ION CTR 3	/13/2008	STEVE	NSVILI	LE. MD
eparti	ce.		21. Signature of Funeral Service Lic	ensee	0 - 0	22. Name a	nd Addre	ess of Facility	3			
D 80E	g 9		- suph M. O	Srowsk. C.	F.SP.	200 S	HAI	RRISON ST	EASTON,	MD_21	601	uorii ta
Physic /Medi Exami	cal		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir a.	the death. Do rie.	rda Pa	de of dyil	my ar	rod	est,		Approximate Interval Between Onset and Death
do / ou, rtificate be executed ig physician and		edical Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of a consequence of	Stage	Re	rul De	isease			18442
The law requires that the death certificate has been signed by the attending place.	Ö	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s		у			Date of delive	ry Day Year
S tha	ne de	Ь	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying	cause giv	ren in Part I.	23e. Did tol	bacco use co	ntribute to th	e cause of death?
v requires been signe	onia		Ny Perfers	we Terl	geore		_		1 Ye	es 2□No	3 Prob	ably 4, Unknown
The law rate has be	page 2 sn	Completed	arrial tu	rullition					24a. Was a autops perfor 1∐ Yes	By	o. Were autor prior to con death? 1 □ Yes	osy findings available npletion of cause of 2 No
VILA sician certifi	long	Be	25. Was case referred to medical examiner?	Hospital:			OA Oth	26. Place of Death				
Phys 9		<u> </u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Out		UA	442 Nursing Ho	me 5 Reside			′)
vttending death. ctor: Afte	auna inua	Certification:	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	(Month, Day	Year) Ir	М		Yes 2 □ No	28f. Location (St			I Route Number
after after		E	4 Homicide determined	building, etc	c. (Specify)		,,		City or Town		noor or rigran	Triodio Manibor,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in properties of the properties of		Medical C	29a. Certifier (Check only one) 1	hysician: To the best of uminer: On the basis of and manner sta	examination and	, death occurred d/or investigation	d at the ti	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and r late and place	manner as st e, and due to	ated. the cause(s)
To t		Σ	29b. Signature and title of certifier William	n HWOO	od MI	29		08715	2	9d. Date sign	ed (Month, I	Day, Year)
6			30. Name and address of person who				***	NOV				
10.0	Stat	e	31. Date filed (Month, Day, Year)		UTCHMAN: ar's Signatur <u>e</u>	S LANE,	EAS'	LUN, MD 21	LOUI			
Reg	gistra		MAR 1 4 2008	Blew 1	1 Som	فيكا						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 19, 2008 Year 1:50 PM Roscoe Humphrey Edward 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jun 23, 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 1**⊠**M 2□F Ĩ935 105-28-1889 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21044 6144 Cedar Wood Drive Columbia 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1953–57 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🗓 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Airline Pilot Air Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Humphrey Veronica Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6144 Cedar Wood Drive Columbia, MD 21044 Jean W. Humphrey/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 03/21/08 Chesapeake Crematory Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concin montris Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

Show

ns 23a or 28a-f sh must be notified

or items 23a

event, the Medical

and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than '

Maryland

Baltimore,

Director

Funeral

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Completed

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physician and s the burial-trans

Physician/Medical

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Completed

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Certification: To

Medical

signed by the a ld be detached f

Records,

Vital

F FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 🗆 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlyi	ng cause given in Part

24a. Was an autopsy performed? Yes 2 No

Charles ST TONSON ND 21204

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

2 No 3 Probably 4 Unknown

examiner?	26. Place of Death (Check only one)								
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 COA Other: 4	□ Nursing Home 5 □ Residence 6 Pether (Specify)							
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred 2 □ No							
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)							

н	29a.	Certifier
н		(Check only
л.		one)
1		

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier		
30. Name and address of person who completed cause of	death (Item 23a)	(Type, Print)

29d. Date signed (Month, Day, Year)

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219	ite

Registra

31. Date filed (Month, Day, Year)



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Registrar DHMH 17 Rev 1/2001

State

(Check only one)

MATHE 31. Date filed (Month)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 8

strar's Signature

29c. License number

RN ST. CAMARIDGE.

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

			State of Maryland / E 1 - State Registrar		rtment of He tificate of D		and Ment		ene g. No.	0000		
		r	Decedent's Name (First, Middle, Last)					ate of Death	h	Z U U C	3. Time of [death
	Physici /Medic		Morgan Leigh Kanner					rch	1 ^{Day}	2008	6:30	АМ
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L Ellicott					ounty of Death		
1000		Q:	2846 Pebble Beach Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday)	If Under 1 Year		24 Hrs. 8. Da	ate of Birth		Howard 9. Birthi	place (State or	Foreian
	Funeral Director			Yrs.	Months Days	Hours	Min. OC	fonth, Day, E 4	^{Year)} 1980	New New	place <i>(State</i> or ntry) Y York	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Loc	ation						10d. Inside City	v Limits
	Maryla f sho ied at	ro	MD Howard Ellic								1 □ Yes	
	n the r 28a	Director	10e. Street and Number		10f. Zip Code			10	g. Citize	n of What Cou	ntry?	
	ath wit 23a c ust be		2846 Pebble Beach Drive		21042					ted Sta		
36	be filed within 72 hours after death with the Maryland that Hygliene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 1		/as Decedent of His Yes, specity Cuban □ Yes 🏖 No	spanic Ori n, Mexican Specify:	gin? (Specity Y i, Puerto Rican	es or No- , etc.)		Black, White,	etc.	
2-0036	tural	ed b			ent's Usual Occupat			11	16b. Kind	VVII of Business/Ir	ite ndustry	
215	thin 72 e. an "na Medik	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	kind of work done du O NOT use retired)	uring mos	t of working					
21	filed wil Hygien rther th	Con	2	Di	sabled	40.84.0				one		
Maryland 21	4 - 9 9	Be	17. Father's Name (First, Middle, Last) Leon Kanner				r's Name <i>(Firs</i> nary Pei			urname)		
Ž	should nd Me mark mark	ဥ		. Mailin	Address (Street ar					Town, State, Zij	p Code)	
Ž	and 2 salth a 1 27 is er trai				Pebble Be		Drive 1	Ellico	ott (City, M	D 21042	2
ore	jes 1 a t of He if item or oth				ition (Name of atory or other place		Date			ation - City or T	,	
Baltimore,	t. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify) Mountain		View Cem.	i	3-24-200			iottsvi	•	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee ## M01044	41	Name and Address	olumb	oia Pike	e Ell:	icot			
×			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	r the mode of dying	, such as	cardiac or resp	oiratory arre	est,		Approximate Interval Betw Onset and D	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Acute Deterior: a. Acute Deterior: Due to (or as a consequence)		on of unkr	nown	origin					
	Examiner		Diabetes Mollis	,								
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	of)·								
68760	ficate be executed y physician and is the burial-transit		d	,-								
_	<u> </u>	l edical									-	
P.O. Box	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23	d. Date of deliv Month		'ear
	res that signed by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause giver	n in Part I.	. 2	3e. Did tob	acco use	contribute to	the cause of de	eath?
ğ	w require been sig should b						_ _	1 □ Ye	s 2	No 3 ☐ Pro	bably 4 □U	nknown
Vital Records,		Completed						4a. Was ar autopsy perform ☐ Yes 2	y	24b. Were autoprior to condeath? 1 ☐ Yes	opsy findings a ompletion of ca 2 No	vailable use of
Vita	ician; Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othor		of Death (Che					
	Physer this eral dir	5 10	27. Manner of Death 28a. Date of Injury 28b. 7	Time of	3 DOA Other	4 🗀 Nu		5 ☑ Reside Describe ho		□Other (Specioccurred	fy)	
<u>0</u>	nding ath. r: Afte e fune	ation	Natural 5 □ Pending (Month, Day Year) I 2 □ Accident investigation	njury		? ′es 2 🔲	1					
Division or	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	ırm, stre	et, factory, office		28f. Lc	ocation (Str ity or Town	reet and , State)	Number or Rur	al Route Numb	ber,
	To the Hospital of within 24 hours at To the Funeral Completely filled in	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination an and manner stated.		estigation, in my op	oinion, dea		the time, da	ate and p	olace, and due	to the cause(s))
/	Tot	Σ	29b. Signature and title of certifier		29c. License	number		29		signed (Month,		
/ <	2)		June 3. Somerel	/Tues 5	D6650				Ma	rch 19,	2008	
_	EG		30. Name and address of person who completed cause of death (Item 23a) (Dr. George D. Lawrence St. Agnes I			Cato	n Ave I	Baltin	more	, MD 21	229	
	Sta Registr		31. Date filed (Month Pay, Year) MAR 2 1 2008 32. Brigistrar's Signature	A.	all .							

Certificate of Death

Day **Physician** Alfred M. Luciani March 15, 2008 11:39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Year) Hours 8/17/1926 Ohio Director 293-12-3691 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Odenton Maryland| Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8604 Wandering Fox Trail 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Year or Dates: 1945–53 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 💢 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Package Handler Federal Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Luciani Laura DeFelice ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Giovenco/ Sister 8604 Wandering Fox Trail, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/19/08 Mt. Olivet Cemetery Washington, D.C. 21. Signature St. Juleral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (*r as a consequence of): **Physician** 72 hour disease or condition resulting in death) /Medical Examiner NUMBAIL Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Ntheroscleratic Heart Dixage Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Stage Physician/Medical iscase IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Sanchez, 2001 Medical Pkwy., Annapolis, Maryland 21401 M.D. 31. Date filed (Mo. gistrar's Signature Year) State Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

24 hours a

Certification: Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/16/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 64VA Honder Sorro 31. Date filed (Month, Pay, MAR)

Registrar

State

32 Registrar's Signature

8 2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1^{Da} 200 8 **Physician** March 8:50 P M Marjorie E. Lopatka /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Lutheran Village Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 17, 1930 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Hours 1□M 21 F Days Delaware 78 Yrs 222 16 0686 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County rthen "nature!; or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐Yes 2 No Director MD Howard Ellicott City 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 United States 3002 Fawnwood Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other then Elementary/Secondary (0-12) Healthcare Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental is marked Thadus McCulley Geneva Hurt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a important: if Item 27 is any injury or other training once. 3002 Fawnwood Drive Ellicott City, MD 21042 John Lopatka/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Gard. 3-25-2008 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 ~ Ot 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cerebroymunlus **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed ding physician and ise as the burial-transit etomueda and that initiated events resulting in death) Last Due to (or as a consequence of) Jivision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1/Natural 2 Accident 5 Pending 1 Yes 2 No death. i Director: A investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 51705 3-20-08 DUY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR, Westminstol, MD 21157 349 malwim PANSURIYA 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008^{eai} Charlotte Louisa Lopus March 5:55AM м 4a. Facility Name (If not institution, give street and number) 3960 Elliott Island Road 4c. County of Death 4b. City, Town, or Location of Death Dorchester Vienna | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 29, Year | 1910 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 💢 F Pennsylvania 98 219-30-3128 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland| Dorchester Vienna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3960 Elliott Island Road 21869 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Adolf Brockman Charlotte Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Johnson/Daughter 3960 Elliott Island Road, Vienna, MD 21869 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 □Removal from State Glen Haven Mem. Park 3/19/2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Signature of uneral Service And 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Scleratic Cardio Vascula 1457210 Due to (or as a consequence of) Sequentially list conditions, if any, bearing to infine diatecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for skip consequence off Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 1□ Yes 2♣No 26. Place of Death (Check only one)

Physician /Medical Examiner Physician/Medical Examiner

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the I

death.

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tn once.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be 2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatilt and Mertal Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other thaumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

physician and s the burial-trans attending pl for use as t signed by the a

9

Be

Certification: To

Medical

page 2 s certificate has

director.

funeral

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Completed 25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier horhe

6 ☐ Could not be

29c. License number 00044282

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year, MAR 1 8 2008



			For State Registrar	State of Ma		/ Depa	artment of F	lealth and	Mental Hy		0000	1080!
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	Physicia /Medic		Alice Loui	se Lyon						_	2008 ^{Year}	0.10 P M
	Examin	er	4a. Facility Name (If not institution, give					r Location of Deat	h	4c.	County of Death	.1.
			St. Mary's Hospit 5. Social Security Number 6. Se		e (In yrs. la:	st birthday)	Leonar	dtown If Under 24 Hrs	8. Date of Bir	th	St. Mary	lace (State or Foreign
10 - 20	Funeral Director				91	Yrs.	Months Days	Hours Min.	October	ly, Year)	Cour	ntry)
	yland yland at		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cour	itry?
	s 23a		38226 Ownes Road	40 Mr Brandont	i= 11.0	140	20624		2		USA 14. Race - Americ	an Indian
	item item iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	iispanic Origin? (S an, Mexican, Puer	to Rican, etc.))-	Black, White,	
5	ırs afi al'; or xaml	þ	3 12 Widowed 4 □ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	••		1 □ Yes 2/√XNo	Specify:			Specify: Whi	te
21215-0036	be flied within 72 hours after death with the Maryland Hygiene. 4 other than "natural"; or items 23a or 28a-f show do other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kii	Kind of Business/Industry	
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0	be filed within ntal Hygiene. ed other than " event, the Mer	BeC	17. Father's Name (First, Middle, Last)		L			18. Mother's Na	me (First, Middle	, Maiden	Surname)	
yland	should be nd Ments marked matic ev	ToE	Herbert Lumbly H	liggs				Sarah	Anna Rio	ce		
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		19a. Informant's Name/Relationship (7)				ng Address (Street					*
a) a)	1 and Health em 27 ther to		James Francis Morgan, 20a. Method of Disposition	/ Grandson	20h Pla		Mount Ster				e, Marylan	
baltimore,	nt of h		1 X Burial 2 ☐ Cremation 3 ☐		cer	netery, cre	matory or other pla	ce) Marc	Date h			
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ñ	Dep Impe		Mulast	Lardy	ier		P.O. Box 270		0 2			101c, 1111
	200		23a. Part . Enter the disease, or comp shock, or heart failure. List only of	lic tions that caused	the death.	Do not ent	ter the mode of dyir	ng, such as cardia	c or respiratory a			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	H4,	Puxi	C	En ceph	rado po	My			Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	nce of):	100					
	Examiner	_	Sequentially list conditions,	b. Due to jor as	1241		*					narce
	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Ca	(& I •	ance off:	9570+	ric.				Minute s
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Į.	requires that the een signed by th nould be detache		Part II. Other significant conditions co			ing in the u	nderlying cause giv	en in Part I.	23e. Did t	tobacco u	use contribute to t	he cause of death?
Records	quire; en sigi uid be	ed by	Carohd s	ite rosi.	<i>'</i>				1 🗆	Yes 2[□ No 3□ Prof	oably 4 Unknown
ပ္သ	law re as bee 2 sho	Completed							24a. Was	an	24b. Were auto	psy findings available mpletion of cause of
_	The ate h page	mo:							perfo	ormed? 2 No	death?	
N Ea	ysician: The law is certificate has b director, page 2 si	Be (25. Was case referred to medical examiner?				1		ath (Check only			-
	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital:		R/Outpatier		4 🗀 Nursing i			6 □Other (Specia	ý)
VISION	Attending I r death. ector: After by the funer.	ation:	27. Manner of Death 1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Day		28b. Time o Injury	Wor	ryat rk? Yes 2 □ No	28d. Describe	now injur	y occurred	
	al or Atters al safter des	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc.		ne, farm, sti	reet, factory, office		28f. Location (City or To		d Number or Run	al Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical (vsician: To the best iner: On the basis of ano manner sta	f examination							
,	Vithi Vithi Comp	Ž	29b. Signature and title of certifier	706			29c. Licens	se number		29d. Dat	te signed (Month,	Day, Year)
			1 1				D617	719		Marc	ch 20, 20	008
			30. Name and address of person who o					1 14 7	1 0000			
	Sta	to.	Dhanan jay Bhavsar, M. 31. Date filed (Month, Day, Year)	D. 24035 Th			ad, Hollywo	od, Maryla	nd 20636			

State Registrar

DHMH 17 Rev 1/2001

MAR 2 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 23, 2008 **Physician** 3:00 AM Dorothy Elizabeth Llewellyn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corriganville Allegany 11314 Featherbed Lane If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2**X**F Director 219-56-0161 67 January 22, 1941 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Director Corriganville Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 11314 Featherbed Lane 21524 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. should be filed within 72 hours after ond Mental Hygiene.

marked other than "natural", or iter 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Mae Grant Thomas Edward Shimer ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Porter Llewellyn - Husband 11314 Featherbed Lane, Corriganville, Maryland, 21524 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any Injury or otl March 27 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens LaVale, Maryland 2008 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Eichnorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 8 East Main Street, Lonaconing, Maryland, 21539 23a. Part. Enter the disease, or convications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner PERTOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death-out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s was an autopsy performed?
Yes 2 No After this certificate 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide LCcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

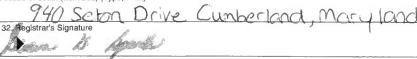
State

31. Date filed (Month, Day, Year) MAR 2 6 2008

103caT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of confifier

Konset



29c. License number

D3875

29d. Date signed (Month, Day, Year)

Registrar

			For State Registrar	State of Maryla	•	artment of H rtificate of L		lental Hygier Reg. N	2000	10807
			1. Decedent's Name (First, Middle, Last)					2. Date of Death	ay Yeer	3. Time of Death
	Physici /Medic		JAMES ROBI	ERT MCCARR	ON				7,2008	7:01A M
1	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of Death	4	c. County of Death	
		٠.	102 Bayland Da	cive, #9		Havre	de Grad	ce H	larford	
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp Cour	lace (State or Foreign
	Director		191-16-8976	M 2□F 83	Yrs.	,		11/28/19:		sylvania
	and *		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation			1	Od. Inside City Limits
	Aaryl	5	MD Harford		•	de Grace	2			1 ☑ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number		navie	10f. Zip Code	-	10g (Citizen of What Cour	ntry?
	with	直	102 Bayland 1	orive #9			078		JSA	,
	hours after deeth with the Maryland tural, or tleme 23e or 28a-f show al Exeminer must be notified at	Funeral		2. Was Decedent Ever in	n U.S. 13.				14. Race - Americ	can Indian,
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8	urs a	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give WW Year or Dates:	/II	1 □ Yes XX No	Specify:		Specify:Whi	te
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21	within 7 ene. then "r	pje	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired				
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P	d is b	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Maid	en Sumame)	
<u>×</u>		၉	Joseph Edward McCa				Lena Tun			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type	<u></u>	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number, City	y or Town, State, Zip	21078
	ss 1 end 2 should of Health and Me Item 27 is mark other traumation		Ann H. McCarron 20a. Method of Disposition		102 b. Place of Dispo			Havre de	Location - City or To	
Baltimore,	Pages nent of thint: if its iry or of		1 ⊠Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crei	matory or other plac	θ)			
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Bal	permit. Pages Depertment of Important: If It eny injury or o		21. Signature of Funeral Service Licens	1 / //	// Ha	2. Name and Addres	H Inc.,	600 Mair	st.	
	10104		22 Part State disease or compli	your	uce			Delta	A, PA 173	1 4 Approximate
			23. Part 1. Enter the disease, or compli- shock, or heart failure. List only or immediate Cause (Final	e cause on each line.	/ /	er the mode or dying	y, such as caldiac	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Lung	Cor	ces	<u>.</u>			18 mmths
	Examiner			Due to (or as a dor	sequence of):					
		<u>-</u>	Sequentially list conditions,	Due to (or as a con:	saguance off.					
	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	-						
Ć,	execi n and ial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as a con-	sequence of):					
8760,	requires thet the death certificate be executed een signed by the ettending physicien and nould be detached for use as the burial-transit	dlcal								
Φ	tificat g phy as th	0								
Вох	leath certifica ettending ph for use as t	5	23b. was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of delive	
	deat e ette	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		Other (specify)			Month	Day Year
P.0	thet the d ed by the detached	hys	9 Unknown	9∐ Unknown						
	res the igned be de	by	Part II. Other significant conditions con	tnbuting to death but not	resulting in the u	nderlying cause give	en in Part I.	2/	o use contribute to t	
Vital Records,	w requir been s should	ed						1 Yes	2 □ No 3 □ Prot	oably 4 Unknown
OC O	law as b 2 sl	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u>~</u>		5						performed 1 ☐ Yes 2 ☑	death?	
ï	sician: Th certificete irector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of <	Physician: this certific ral director,	၉	1 ☐ Yes 2 No		2 ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursing Ho	me 5 Residence	6 ☐Other (Special	(y)
n n		ä	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injun Work	at k?	28d. Describe how in	jury occurred	
Sio	Attending r death. sctor: After by the fune	cati	2 Accident investigation			M 1	Yes 2□No			
Division	al or Attend after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · A building, etc. (Sp	At home, farm, str <i>ecify)</i>	reet, factory, office		28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by									
	e Hospital 24 hours a Funerel I	Medical	29a. Certifier (Check only one) 2 Medical Examination	ician: To the best of my ler: On the basis of exam	knowledge, deat nination and/or in	h occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner as s and place, and due t	tated. o the cause(s)
	To the within 2. To the Complete	Med	29b. Signature and life of certifier	and manner stated.)	29c. License	e number	29d. I	Date signed (Month.	Dev. Year)
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7			20 Name and address of the same	ig in	100 mm	Dairy To Dair	Au Ca	u Cot	16.1	
				violetan cause of death (пет 23а) (Туре, 🕖	Chit L	200. 910	7 Frankl.	SA	Bolton me
	Sta	to	31. Date filed (Month, Day (Year)	2 A2 Registrar's Si	ignature	1	7,00) /	200.1	入1)2-
	Registr		APR U	Zhno -	was St	Special .		ce, Cat Frankles		7

			For State Registrar	State	of Marylan			t of Hea e <i>of De</i>			giene) (008	10808
E	Physicia		1. Decedent's Name (First, Middle		e Marie 1	Mills		•		2. Date of Dea Month March 1	th	O8 Year	3. Time of Death 2:00 P M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and no	umber)		'		cation of Death		4c. Cou	nty of Death	<u> </u>
-	Funeral		Washington Co 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		Under 24 Hrs.	8. Date of Birth	1	ningto 9. Birthp	lace (State or Foreign
ŭ.	Director		225-54-7300	1□M 2∭F	64	Yrs.	Months	Days H	lours Min.	Dec. 18	3, 194.	3 Mar	yland
9	NOW THE		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
Mo	Ba-f et	ctor	MD Washi	ngton	Kn	oxvill	e						1 ☐ Yes 2 X No
46,71	S or 2	Dire	10e. Street and Number 18806 Sandy	Hook Rose	1		10f. Zip	758				of What Co <i>u</i> r USA	ntry?
4	me 23	Funeral Director	11. Marital Status		cedent Ever in U.	S. 13. V	Was Dece	dent of Hispan	nic Origin? (Spo	ecify Yes or No-	14. F	Race - Americ Black, White,	
2	permit Feggs 1 and 2 should be filled within 72 hours after begin with the mary and Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other treumatic event, the Medical Examiner must be multilled at QDCs.	by Fu	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2 X No live		1 ☐ Yes		pecify:	, , , , , , , , , , , , , , , , , , , ,	Spe		
בל ה	nature		15. Deceder	nt's Education		16a. Deced	ient's Usua	al Occupation	n an most of work	ina	16b. Kind of	f Business/In	
7	than "	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		oo noru: ewife	-	ig most of work		Home	naker	
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À	Menta Marked Marked	To	Frank E. Went						Edna Asl				
Mar	ith and tth and 27 ts m		19a. Informant's Name/Relations Charles R. Mil		Husband		-			al Route Numbe - Knoxy			
e,	of Hea		20a. Method of Disposition 1 Burial 2 □ Cremation		20b. P	lace of Dispo	sition (Nar	ne of ther place)		Date	20c. Locatio	on - City or To	own, State
	r. reg riment riant: I rjury o		4 Donation 5 Other (5	Specify)	Bro				em. 3/14			sville	
0	Deper Impo eny i		21. Signature of Funeral Service Robert L	. See-	M9			nd Address of Harpe	Lace	ckles-Sp cy, WV 2		& Nor	ton Funeral
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the deat each line.	h. Do not ent	er the mod	le of dying, sa	uch as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	y o ca	vence of):		~fzr	-ctm				5 minuts
	Examiner		Sequentially list conditions	b		201100 01 7.							
3	nsit	Examiner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diná to	i (isr as a dishsaq	uence of):						- 1	
ĵ.	execu en and rial-tra	Exar	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of);							
00/0	cale be executed physicien and the buriat-transit	dicai		d									
XOC I	anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		75				23d.	Date of delive	ery
2 2	ine law requires mat the death centil ite hes been signed by the ettending bage 2 should be deteched for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		birth 2 ☐ Feta gnant at time of d nown		Ectopic participation Other (sp					Month	Day Year
	nat tr ned by detec		Part II. Other significant conditi	ions contributing to	death but not res	ulting in the u	ndertying o	ause given ir	n Part I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
Vital Records,	equires en sign ould be	ted by	Cirrhosi							1 🗆 Y	′es 2.23KNo	o 3 ☐ Prot	pably 4 □Unknown
9	hesbe	Completed	Diabete	1 Mel	litus					24a. Was		lb. Were auto prior to co death?	opsy findings available impletion of cause of
	ifficate or, pag		25. Was case referred to medical	aj				26	S Place of Deat		2 XNo	1 Tes	2 No
7	tending Physician: The la leath. tor: After this certificate hes the funeral director, page 2	To Be	examiner? 1 ☐ Yes 2 💢 No	Hospital:]Inpatient 2∭	ER/Outpatier	nt 3□ DC			ome 5⊟Resid		Other (Specia	fy)
בום סוב	ding P	tion:	27. Manner of Death 1 X Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time of Injury	f M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe h	now injury oc	curred	
DIVISION	To the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ce of Injury - At h	ome, farm, str				28f. Location (S	Street and Nu	umber or Rura	al Route Number,
5	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier 1 X Certifyi	ng Physician: To t			b converse	at the time	data and place	and due to the	201120(2) 224		
:	n 24 hc n 24 hc ne Fun sletely	edicai	(Check only 2 Medica one)	I Examiner: On the	basis of examina inner stated.	ition and/or in	vestigation	, in my opinio	on, death occur	red at the time,	date and place	ce, and due t	o the cause(s)
	Vithi To t	Σ	29b. Signature and title of certific	& Lev.	~		29	c. License nu				gned (Month,	
1	0		30. Name and address of person	,			Print)	D41	619	1	MAN	h 13	, 2008
1	~		Michael Lerner	, MD - 63	3 Thomas	Johns	on Dr		Suite 1	E - Fred	derick	, MD 2	1702
	Sta Regista	ate rar	31. Date filed (Month, Day, Year	AR 1 3 200	Registrar Signa	ature	4	and I					

burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the as for use detached þ page 2 Physician: filled in by the funeral director, this or Attending death.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

death with the Maryland

72 hours after

Pages 1 and 2 should be filed within

land

Maryl

altimore,

nd Mental Hygiene.

It of Health and Mental

or other traumatic

Department of Important: If any injury or once.

Physician

/Medical

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated warms.) Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 Homicide Hospital 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29 glew H MD DDD 59939 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AU+8 EEE lliot Family Physicians 90ston 508 Idlewild 31. Date filed (Month, Day, Year) egistrar's Signature State 2008 Registrar



Please	Type o	r Print in	Black	Indelible Ink.	Ensure	All Copies	Are Legible.
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State of Maryland /	Department of Health	and Mental Hygien
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			For	State of Mar	yland	-			Mental Hy	giene	9	
	_	_	State Registrar	-0		Cei	rtificate of	Death		Reg. No	2000	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Dea	Da		6:00 P M
	/Medi		John Andrew Mat				4b. City. Town, o	r Location of Death	March 2		2008 County of Death	
	Examir	er	24150 Speith Ros					onardtow			St. Ma	
	Funeral		5. Social Security Number 6. S		'In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.		h	9. Birth	place (State or Foreign
- 64	Director		219-46-9948	1⊠M 2□F	60	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day May 15	, 19	47 Mar	intry) cyland
	pu. »		Usual Residence of Decedent 10a. State 10b. County	1	Oc City	Town or Lo	cation					10d. Inside City Limits
	laryla shov	5			oo. Oity,	TOWN OF EO		onardtow	-			1 □ Yes 2 🗓 No
	the N 28a-f	rect	Maryland St. Ma	ary's			10f. Zip Code	onardlow		10a. Ci	tizen of What Cou	untry?
	with 3a or	Funeral Director	24150 Speith Roa	he.			·	650			USA	
	death ms 2 r mus	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	. 13.		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	-	14. Race - Amer Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:			1 □ Yes 24 No	Specify:	o rican, etc.)			nite
5-0	72 ho natur dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual Occup	oation during most of wor d)	rking	16b. K	(ind of Business/I	ndustry
21	/ithin ne. han "	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	. ,			_{d)} echnician		Τī	S. Gover	nment
2	iled w Hygiei Iher tl	ပိ	12 17. Father's Name (<i>First, Middle, Lasi</i>	1		erecri	TOILTES TE	18. Mother's Nan				IIIIEIIC
anc	ntal hed of	BB	James Virgil Matt						L. Hall			
Ž	should id Me mark matic	우	19a. Informant's Name/Relationship			19b. Mailir	na Address (Street	and Number or Ru				ip Code)
≥ S	nd 2 s Ilth ar 27 is r trau		Sara Ellen Mattingly	/ Wife			-	onardtown,				
Baltimore,	of Hear		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of	ce) Marc	Date	20c. L	ocation - City or	Town, State
E O	Page nent c int: If		1 XBurial 2 □Cremation 3 □ 4 □Donation 5 □ Other (<i>Speci</i>		Quee	n of Pe	matory or other pla Pace Emetery	26,	2008	He	len, Maryl	and
att	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	nsge,)					• •			1 Home, P.A.
	825 2 2		Muchael	Faroliner				0, Leonardt			20650	
V.			23a. Part1. Enter the disease, r con shark, or heart failure. List only	one cause on each line.								Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Mes	173	TATI	c //	devoc	MACINE	mb	,	Years
	/Medical Examiner	Ш	Testiang in detaily	Due to (or as a	conseque	ence of):						
- 8	3	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	conseque	ence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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9	ertifica ing ph e as t	Med	IF FEMALE:									
Вох	ath o attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf	Fetal	death 3	Ectopic pregnanc	ey .			23d. Date of deli Month	very Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at tir 9⊡Unknown	me or dea	ain 5L	Other (specify) _					
, P.O	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions						23e. Did t	obacco	use contribute to	the cause of death?
rds	quires n sigr ald be	d by	Cono	UARY 1	10.	TERY	11150	75	1 🗆 '	Yes 2	2 □ No 3 □ Pr	obably 4 Onknown
O	law rec as bee 2 shou	Completed							24a. Was		24b. Were au	topsy findings available
æ	The la te has	dmo							autoj perfo 1⊟ Yes	psy ormed? 2 1	death?	completion of cause of
Division or Vital Records,	ian: rtifica xtor, p	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only o		0 1 10100	223110
>	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 <u>□</u> E	R/Outpatier	nt 3□ DOA Oth	ner: 4□ Nursing H	lome 5 Resi	dence	6 □Other (Spec	cify)
0 4	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year)	28b. Time o Injury	Wo		28d. Describe	how inju	ary occurred	
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Ξ	or At fler d Direct in by	Certification:	4 ☐ Homicide determined		y - At horr (Specify)	ne, farm, sti	reet, factory, office		City or Tol			ıral Route Number,
, 🗀	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	hysician: To the best of	my know	ledge deat	h occurred at the t	ime_date and place	e and due to the	causel	s) and manner as	stated
120	24 hc 24 hc Fun etely	Medical		miner: On the basis of e	xaminatio							
W	To the within To the complex c	Me	29b. Signature and title of certifier	m -1 .0	1.1		29c. Licens	se number			ate signed (Monti	
	1 21 0			m. Frela			2	37000			3/24/	08
			30. Name and address of person who	completed cause of dea	th (Item 2	23a) (Type,	Print)		0 11	70	11 Nun	0
_			1/19010	m. rede	1-6	140	116 20	00-	na	2	0636	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar'	s Signatu	119	0	, .				
	Regist		MAR 2 5 2008	Store A	1	1						
DF	IMH 17 Rev 1/2	:001	**			0	RIGINIAI					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2008 2:22 AM March 21, Mary Elizabeth McKenzie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Care Center Frostburg Allegany If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Oct. 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🔀 1921 Maryland Director 212-38-5939 Usual Residence of Decedent 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits show at a or 28a-f she be notified a 1X Yes 2 No Director Garrett Grantsville MD 10g. Citizen of What Country? 10e. Street and Number ns 23a 143 Grant St. 21536 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married "natural", or it edical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ School Teacher Education Ith and Mental Hygid 27 is marked other r traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin William Schaefer Bertha Reckner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr Clinton J. McKenzie/Husband P.O. Box 366, Grantsville, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cemetery March 25, 2008 Grantsville, MD 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. eurosa P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation hours after death, ineral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Dr. Harjit S. Sidhu, M.D., 925 Bishop Walsh Rd., Cumberland, MD 21502
31. Date filed (Month, Day, Year) 32. Registrar Signature

Healle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D26907

MARCH ZI ZUOS

Pichard	William	Miller	

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		For State		Cer	tificate of	Death			Re	eg. No.	£ 0		001
Physician		. Decedent's Name (First, Midd											th
rdical Examin		Richard Willia	am Miller	March 24,	2008		1351 hrs						
	4	a. Facility Name (if not institution	on, give street and nu	mber)		4b. City, Town, o	r Location of	f Death		1	nty of Dear	th	
		59 Clover Lane Apart	ment # 5		ļ	Accident				Garre			
Funeral	5	. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye			8. Date of Bir	th(MM/DD/Y	YYY) 9. Bi Fore	irthplace (State or	
Director		213-44-1323	1X M 2 F	66	Yrs	Months Da	ys Hours	Min.	May 5,	1941		ountry) PA	
	H	Jsual Residence of Decedent											
any	_	0a. State 10b. County		10c. City,	Town or Locat	ion						10d. Inside City	y Limits
		MD Garre	>++	Acc	ident							1 Yes 2	X No
Aaryland 28a-f show 1 at once.	휘	Oe. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Co	untry?	
th the Maryland 23a or 28a-f sho notified at once	Director					07.5	00		[***	7		ļ
th the		59 Clover Lane		Land Francis III	0 140 144	215 as Decedent of F		nin2 (Spec	ify Yes or No	US.		erican Indian, Blad	ck,
t be	ig i	Marital Status Never Married 2 N	Married Armed F	cedent Ever in U orces?	.s. 15. W	es, specify Cub	an, Mexican,	Puerto Ri	ican, etc.)		White, etc.		- 1
or it	Funeral		1 Yes	2 χ No		Yes 2 x	lo specify:			Spe	^{cif} /whit		
after	اھ		vorced If Yes, Give Yes		I 16a Deceder	nt's Usual Occup		kind of wor	rk done		of Busines:		
hours		15. Decedent's Education (Special Control of the Co			during m	nost of working li	fe. DO NOT	use retired	d)				
n 72 n 72 nan "	ompleted	Elementary/Secondary (0-12)	′		Cabool	l Teache	*			Educa	tion		
withi ier th	틹	17. Father's Name (First, Middle	4+ye	ears	SCHOOL	reache	18.Mother	's Name (F	First, Middle,	Maiden Surr	name)		
Hyg d oth	ပို		e, Last)				1		ounkir				ŀ
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	m	Carl Miller 19a. Informant's Name/Relation	ohin /Tuno Print \		19h Mailir	ig Address (Str	eet and Num	nber or Ru	ral Route Nu	mber, City o	r Town, Sta	ite, Zip Code)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she amatic event, the Medical Examiner must be notified at once	리					Aiken-M						1520	
	}	Ralph F. Millo 20a. Method of Disposition	er/brother		Place of Dispo	sition (Name of	cemetery,		Date	20c. Loca	ation - City	or Town, State	
S 1 an of the strain of the st		1 Burial 2 X Cremation	on 3 Removal f	Ctata	crematory or o	ther place)		ا م	2000		د سساند د	11- 01	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		4 Donation 5 Other 5	Specify:	Co								lle, PA	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service			Ne Ne	Name and Addre	ess of Facilit ineral	y Home	s,P.A.	, P.O	. Box	275	
w 52 5 11 11		23a. Part I/Enter the disease, o	maer		11	79 Mille	r St.	, Gra	ntsvi	llo, M	D 21	536 Approximate	a Interval
Physician	П	23a. Part I Enter the disease, of failure List only one caus	or complications that	caused the deat	h. Do not enter	the mode of dyir	ng, such as c	cardiac or i	respiratory a	rrest, shock,	Oi fieatt	Between Or	nset and
/Medical	- 20	Immediate Cause (Final diseas	A 41 1-	rotic Cardio	vascular Di	sease						Dea	iui -
aminer	- 1	or condition resulting in death)		a consequence	of):								
	.	Sequentially list conditions,	b					_					
	Examiner	if any, leading to immediate cause. Enter Underlying Caus		a consequence	of):								
	lai.	(Disease or injury that initiated events resulting in death) Last	D	a consequence	of):								
nted d ansit		events resulting in death) Las.	ď.										
760, ficate be executed g physician and the burial - transit	Physician/Medical	UNPENDED	AMENDED										
e be o	ed	IF FEMALE:	23c If yes	, outcome of pre	egnancy			-		23d. D	ate of deli	very	
8760, ificate bong physic	1	23b. Was decedent pregnant in		birth	2 T	etal death	3 Ectop	ic pregnan	псу	Mo	onth	Day	Year
Box 687 e death certificate at the attending	ig	past 12 months?	,	nant at time of	Leadle Co	Other (Specify)				- 1			8
Bo) deatl	S			nown	1				TI TO DI		1.11	to the equipo of o	doath?
O. I at the tacke		Part II. Other significant cond	ditions contributing	to death but not	resulting in the	underlying cau	se given in P	Part I.				e to the cause of corobably 4	
ires that the de signed by the	d b									es Z N			
ds,	Completed								24a. Wa	is an opsy	24b. Were prior	e autopsy findings to completion of	cause of
COT law I has t	힏		-							formed?	deat		No
Re The Track	ঠ					26 D	ace of Death	h (Check o		2110		700 - 1	
Za Za Za Za Za Za Za Za Za Za Za Za Za Z	Be	25. Was case referred to medi examiner?	Hospital:		7 5D/0 4		Other ₄		g Home 5	Residenc	e 6 🗸 0	ther: Scene	
Physical Circuits and drive and driv	ဥ	1 ✓ Yes 2 No	- L-	Inpatient 2	ER/Outpatie		injury at Wo		28d. Describ				
ing P	Ë	27. Manner of Death 1 ✓ Natural 5		te of Injury hth, Day,Year)	Zob. Time C		Yes 2	- 1	200. 2000				
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rather ceath. al Director: After this certificate has been signed by the fumeral director, page 2 should be detach.	Certification:		ending vestigation						OOF Leasting	(Ctroot ppd	Number	r Rural Route Nur	mber City
VIS Per c	ific	3 Suicide 6 C	ould not be	ace of Injury - At	home, farm, st	reet, factory, offi	ce building,	etc.	or Towr		i Number o	T TOUTE TOUTE THE	
pital Di	Seri	4 Homicide	etermined (Specif						_				
Hosy 24 hc Fun	a	CHOOK OIN	Physician: To the b	est of my knowle	edge, death oc	curred at the time	e, date and p	place, and	due to the ca	ause(s) and i	manner as	stated. to the cause(s)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after ceath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical E	xaminer: On the basi	of examination r≲tated.	and/or investi				it die tille, U				-1
F § F 8	Me	29b. Signature and title of cert					ense numbe	er			-	(Month, Day, Year	1)
			4/6	2		0	.C.M.E.			Marcl	h 25, 20	υ <mark>ၓ</mark>	
		30. Name and address of pers	son who completed ca	ause of death (It	em 23a)								
	3	David Fowler M.D.	Chief Medical		111 Penn	Street, Balti	more, MD	21201					
	-			10.4						-			
	tate	31. Date filed (Month, Day, Ke	ar) 9 // ၁ՈՐ32.	Registrar's Sign	ature	All and Bell	-						

		For	se '				d / Dep	artmer	nt of H	lealth	and N	II Copies Iental Hy		_	ible.		
	ו	State Registrar					Ce	ertificat	e of L	Death	7		Reg. No	.20	108	1.10	813
Physician		 Decedent's Name (First, Middle 		" ike Oha	min	2						2. Date of D Month March	Death 15		008	3. 1 me o	0 PM
/Medical Examiner		1a. Facility Name (If not institution				.1		4b. City	Town, or	Location	of Death	Marci			of Death	12.0	O F
LAGIIIII		5040 Nethersto	ne	Court				Co	lumb					Hov	vard		
Funeral Director		5. Social Security Number 086 62 4360 Usual Residence of Decedent	6. Se	ex □M:2 X F		(In yrs. I 54	last birthday Yrs.	/) If Unde Months	n 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of B (Month, D Nov 16	Day, Year	53	Cou	place (State ontry) many	or Foreign
yland low at	- 1-	10a. State 10b. County	,		ļ	10c. City	, Town or L	ocation								10d, Inside C	ity Limits
e Mar a-f sh tiffed		MD Howa	rd			Co]	lumbia	à								1 ☐ Yes	2 1 No
hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at ed by Funeral Director		10e. Street and Number		_				10f. Zij							What Cou	•	
fter death w		5040 Nethersto	ne	12. Was De	codent S	Ever in III	S 13		1045		rigin? /Sn	ooifu Voe or N	_		ed St	ates can Indian,	
fter d r item niner		 Marital Status Never Married 2XMar 	ried	Armed F 1 ☐ Yes	Forces?		0.		_			ecify Yes or N Rican, etc.)			ck, White,		
ours a		3 Widowed 4 Divorced		If Yes, G Year or	Bive Dates:			1 ☐ Yes	21 3(No	Specify	<i>/</i> :			Specif	^{y:} Whi	te	
72 'na dic		15. Deceder (Specify only highe	nt's Ed	ucation de completed	f)		(Giv	edent's Usu e kind of wo	ork done d	durina ma	st of work	ring	16b. k	Kind of B	lusinėss/Ir	dustry	
ifled within 72 I Hygiene. other than "natent, the Medic	1	Elementary/Secondary (0-12)		College 2	(1-4or 5-	+)		no not u		,	an		H	iospi	ital		
be filed tal Hygi d other event, t	1	17. Father's Name (First, Middle,	Last)					-n.aoy	10011			e (First, Middl	-				
Menta arked atic ev		Werner Prigge								Anr	na St	orch					
2 sho		19a. Informant's Name/Relations			/ •	_	1	_				ral Route Num				,	
1 and Health em 27 ther t	+	Christopher J.	Or	anıan/	Husl	_		Oosition (Na		one		Colum				own, State	
ages ant of t: If its y or o	1	1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5			n State	C	emetery, cr	ematory or Crema	other plac	1					•	ryland	
permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, the once. To Be Co	H	21. Signature of Funeral Service	<u> </u>		001	40104						-2008 су Н. W					
permi Depa Impo any ir		Sem Oli	ln	=- With	phi	1010						ike El					
Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	r comp	a. Due to	each lin	the death e. 3 a consequ	uence of):	MUH		-	s cardiac	or respiratory	arrest,			Approxima Interval Be Onset and	ween
certificate be executed ding physician and ise as the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last		d			uence of):										
The law requires that the death certificate be the has been signed by the attending physicic age 2 should be detached for use as the but ompleted by Physician/Medical		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth gnant at	pf pregna 2 □ Fetal time of de	I death 3	□Ectopic p □ Other (s		<u>'</u>					ate of deliv	ery Day	Year
w requires the been signed should be de	. !	Part II. Other significant conditions of the significant condition	ons co	entributing to	MIA	it not resu	ilting in the	underlying o	ause give	erfin Part))				tribute to	the cause of bably 4)	death? Unknown
		05 Manager 4 and 4 and 4				J						per 1□ Yes	opsy formed? 2 XN		prior to co death?	opsy findings ompletion of d	available cause of
Physiclan: r this certifica ral director, p	ľ	25. Was case referred to medica examiner? 1 ☐ Yes 2 X No		Hospital: 1] Inpatie	nt 2∏I	ER/Outpatie	ent 3 □ D	OA Othe	or.		h <i>(Check only</i> ome 5 ⊠ Res		6 🗆 Otl	her (Snec	f _V)	
on office of the	1	27. Manner of Death 1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	gation		e of Injur onth, Day		28b. Time Injury	of M	28c. Injun Work			28d. Describe					
		3 Suicide 6 Could 4 Homicide detern	nined	buil	ding, etc	:. (Specify	/)	treet, factor					own, Stat	te)			nber,
To the Hospital within 24 hours of To the Funeral completely filled Medical Ce		(Check only 2 Medical one)	Exam	iner: On the	ne best of basis of inner sta	examinat	wledge, dea tion and/or	investigation	n, in my o	pinion, de	and place, eath occur	and due to th	e, date ar	nd place	, and due	to the cause(s)
With Cor		29b. Signature and title of certific	de	dale	X				C. License		109	19	0.0	Chi	18	2003	,
E.G. State		30. Name and address of person 31. Date filed (Month, Day, Year)	le,	lee -	34	fu-	CRE	Print)	550	0 6	Ver	19 18#	-1	n/	6-1	suto	KIL
Registrar		MAR 1	9 2	2008	lee	w.	ture	freele									,- 0

Drivin 17 Rev 1/2001

		For	State of Maryland / D			Mental Hyg	iene		
		1 - State Registrar		Certificate of	Death		eg. No. 2	08.	108
Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Helen Grupp Pasqu	ale			2. Date of Deat Month March		ear	3:45 P
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	or Location of Death	1	4c. County of	Death	
		Lorien Nursing & Re 5. Social Security Number 6. Sex		Columbia		8. Date of Birth	Howard) Riethplace	(State or Fore
Funeral Director		057-14-5860	M OF VE	Yrs. Months Days	Hours Min.	July 18	, 1919 S	Country) Witzer	land
and 		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. I	nside City Limi
f sho	ō	Maryland Baltimore	Catonsy	ri110				1	I □ Yes 2 1
28a- notif	rec	10e. Street and Number	caconsv	10f. Zip Code		1	0g. Citizen of Wh	at Country?	
3a oi	O IE	5909 Fox Hall Manor	Drive	21228		1	USA		
iges I and 2 should be lifed within 72 hours after bean with the maryland. It of Health and Mentall Hygiene. If ifem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	Black,	American In White, etc.	ndian,
tural",	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	Decedent's Usual Occup			16b. Kind of Busin	White	3/
ne. nan "nai e Medica	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of wor	rking			y
her th			Sec	retary	19 Mothor's Nar	ne (First, Middle, I	Education		
ed otl	Be	17. Father's Name (First, Middle, Last) Arthur Grupp			Frances		viaideri Surriame)		
s marke	မ	19a. Informant's Name/Relationship (Type	ne Print) day abt an 19b.	. Mailing Address (Street			r. City or Town. St	ate. Zio Coo	ie)
ealth an n 27 is ier trau		Catherine Pasquale	Tohngon	009 Fox Hall					
f Hea item othe		20a. Method of Disposition	20b. Place of	Disposition (Name of ry, crematory or other pla	i		20c. Location - Ci		
nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Chesape	eake Cremat	ory 03/2	20/08 B	eltsvill	e, MD	
Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service License	elle M01251	Going Hom Beverly L					
raminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Urinary Tract In	of):					
physician and the burial-transit	dical Ex	Country in occasi, 22st	Due to (or as a consequence of	orj:			-		
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	ÿ		23d. Date Monti	-	/ Year
been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	ute to the ca	
e has beer age 2 shou	Completed					24a. Was a autops perfor	sy pri med? d <u>e</u>	or to comple ath?	findings availation of cause
		25. Was case referred to medical			26. Place of Dea	1 Yes ath (Check only or	IX	Yes 2□	1140
r this certificate has ral director, page 2	To Be	examiner? 1 X Yes 2 No H	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Ot		lome 5 ☐ Reside		(Specify)	
After th uneral		27. Manner of Death 1 X Natural 5 ☐ Pending		Time of 28c. Injury Wo	ıry at ırk?		ow injury occurred		
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)]Yes 2□No	28f. Location (S. City or Town	treet and Number n, State)	or Rural Ro	oute Number,
e Funeral letely filled	Medical Co		ician: To the best of my knowledge ner: On the basis of examination an and manner stated.						
within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier		29c. Licen	se number	2	29d. Date signed	(Month, Day	, Year)
	S		RMO		53150) M	arch 19,	2008	
EG.		30. Name and address of person who co Shakunmala Gupta,	mpleted cause of death (Item 23a) (M.D. 9650 Santia;	Type, Print) go Rd. #110	Columbia	a, MD 210	45		
Sta		31. Date filed (Month, Day, Year) MAR 2 1 20	32. Pegistrar's Signature	Societies					

DHMH 17 Rev 1/2001

			For State	State of	Marylan		artment of rtificate of			-		008	10815
			Registrar 1. Decedent's Name (First, Middle	e. Last)			Timeate of	Dean	-	2. Date of De	Reg. No.		3. Time of Death
	Physic		William	Wade	P	i1kert	on			Month March 2	26. 200	Year 8	М
V	/Medi Exami		4a. Facility Name (If not institution				4b. City, Town,	or Location	of Death	riar oii i	1	y of Death	0250
1	LXamii		Charlotte Hall	Veterans	Home		Char	lotte	Hall	L	S	t. Ma	ry's
	Funeral Director		5. Social Security Number 577–40–3177	6. Sex X	7. Age (<i>In yr</i> s. 83	last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bird (Month, Da Dec. 18	h v. Year)	9. Birth	place (State or Foreign intry)
	yland now at		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				-		10d. Inside City Limits
	the Mar 28a-f sh	Funeral Director	Maryland St.	Mary's		Char	1otte Ha				10g. Citizen of	What Cou	1 ☐ Yes 25€No
	with 3a or t be	Ö	29449 CHarlott	e Hall Roa	đ			622				S A	,
	ms 2 mus	Jera	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13,	Was Decedent of If Yes, specify Cu		rigin? (Sp	ecify Yes or No			can Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give	2 □ No e		If Yes, specify Cu 1 ☐ Yes 2 🕱 No			Rićan, etc.)	Speci	ack, White, ify: W	, etc. hite
0	72 hor	Completed by	15. Deceder	it's Education st grade completed)			dent's Usual Occi		act of wark	ina	16b. Kind of I	Business/Ir	ndustry
218	within 7 iene. than "r the Med	Pe Pe	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use retir	ed)	St OI WORK	ing			
	ed wi ygjen ier th	ပ္ပြ	12				Drive	1					xpress
Maryland	should be fil and Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Charles W	*	.1kerto	n			_{ner's Name} garet	e (First, Middle, :	A.	_{me)} Keye	S
ary	2 shot and N is ma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Stree	et and Numi	ber or Run	al Route Numb	er, City or Towl	n, State, Zi	p Code)
	and 2 ealth n 27		Charles W. Pil	kerton/Nep			Lydale P	lace,			06450		
ore	Jes 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Bemoval from S		Place of Dispo cemetery, cre	osition (Name of matory or other pi	ace)		Date	20c. Location	- City or T	own, State
Ë	Pages ment of I ant: If its		4 Donation 5 Other (5		Ma	ryland	Veteran	s	4/4/	2008	Chelte	nham,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service		M00817	B 30	2. Name and Add rinsfiel 0195 Thr	ress of Faci d–Echo ee No	ols F tch R	uneral	Home, l	P.A. Hall	, MD 20622
	28.5		23a. Part1. Enter the sease, o shock, or heart failure. List	r complications that ca	rused the deat ach line.								Approximate Interval Between
-	Physician	ш	Immediate Cause (Final disease or condition	hun	exina	tren	nia					2	Onset and Death
7	/Medical	П	resulting in death)	a. ueto	r as a conseq			- 8					Weeks
8	Examiner	L, I	Sequentially list conditions	ь С	eme	enti	a -	ad	Var	nced ult (- Sei	rere	years
	P #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts	Due to (d	or as a conseq	uence of):	1123		1	11	\		l
	ecute and -trans	Kam	that initiated events resulting in death) Last	c. Dia	bete or as a conseq	S IV	ellit	rs -	MO	uit (Inset	-	years
8760,	ate be executed thysician and the burial-transit		,			. ,	Arten	. 7	·21/	ease			2100.00
87	cate physi	dical		d. OY	ona	79	IVION	1 1	<u> </u>	<u> </u>		-	years
Box 6	The law requires that the death certifics the has been signed by the attending proage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4□Pregna	rth 2 ☐ Feta ant at time of d	ldeath 3	□Ectopic pregnan □ Other (specify)	су	_			ate of deliv	very Day Year
P.0.	it the d by the tached	hys	9 ☐ Unknown	9□Unkno	wn								
or Vital Records, F	luires than signed I	ğ	Part II. Other significant conditi	ons contributing to de	ath but not res	ulting in the u	nderlying cause g	iven in Part	1.	23e. Did to		ntribute to 3 ☐ Pro	the cause of death? bably 4 Unknown
S	w requir b been si should l	lete	huno Hu	india	Sm	_				24a. Was	an 24b	. Were aut	opsy findings available
Re	The la te has	Completed	history of	Passes	<u> </u>		GLB	1000	1000		rmed?	prior to co death?	ompletion of cause of
ta	an: 'rtiffica'rtor, p	Be C	25. Was case referred to medica	recurv	ent L	ower	al D			1 Yes h (Check only o	2 No	1 ☐ Yes	2☐No
\ \	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ 🚜 o	Hospital: 1 ☐ Ir	patient 2	ER/Outpatier	nt 3□ DOA O	Ale		me 5 Resid		ther (Speci	ifv)
0 0	ig Ph ter th	اڃا	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date o	f Injury n, Day Year)	28b. Time o	f 28c. Inj			28d. Describe I			
<u>Si</u>	endlr ath. or: Af	atio	2 ☐ Accident investi	gation	,,,,,	,,		Yes 2	□No				
Division	ir Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	sined 28e. Place	of injury - At ho ig, etc. (Specif	ome, farm, sti	eet, factory, office	Э		28f. Location (5 City or Tox		ber or Rui	ral Route Number,
	ital o	Š								-			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2.	ledical	29a. Certifier 1	ng Physician: To the Examiner: On the ba and mann	sis of examina	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date a opinion, da	and place, eath occur	and due to the red at the time,	cause(s) and n date and place	nanner as e, and due	stated. to the cause(s)
	Vithi To th	M	29b. Signature and title of certifie	A			29c. Licer	nse number			29d. Date sign	ed (Month	, Day, Year)
			Parel	& Ten	in	2	Do	150	92		3 2	6/2	2008
			30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	١,	_	- ,	\ /	Λ.	N 0 = 1 = 6
			110 Hospitz	u Koao	CSU	ute	205 +	ninc	eti	reden	rick	, M	D 20678
	Sta Regist		31. Date filed (Month, Day, Year)	\$2. Re	egistrar's Signa	could 1						•	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear Physician 9:37 PM Peggy Kamse 2008 March /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Anne Arundel Annapolis Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Davs Hours 1 □ M 2 🗷 F 83 Director July 31,1924 F1orida 262-32-6397 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified. 1X Yes 2 No Director Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1424 Catlyn Place 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DAV Auxilary National Commander 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ben Schmitt Ida Baker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1424 Catlyn Place Annapolis, Joe F. Ramsey, Jr./ Husband MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State Kalas Crematory Other (Specify) 3-15-08 4 ☐ Donation Edgewater, MD 21. Signature of Fune al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home CH 2973 Solomons Island Rd., Edgewater, MD 21037 2 M. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immedia to Cause (Final disease or condition resulting in death)

a.

Due to (or as a construence of): Approximate Interval Between Onset and Death 3 WCC | \$ Physician /Medical Due to (or as a cons uence of): **Examiner** volume Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pseudomembranous sician and burial-trans Due to (or as a consequence of): Hox 68760, ettending physician or use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. sate has been signed by the page 2 should be detached 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed infarction myo cardial 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 Natural 2 ☐ Accident Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours afte To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D39104 MD 2008

10CH

MS

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 7 2008

Campbe

30. Name and address of person

Kurtis

MD, 600 Ridgely Avenu 32. Registrar's Signature 18 Show & South

completed cause of death (Item 23a) (Type, Print)

Suite 222

Annapolis Maryland

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 ELEANOR M. REYNOLDS MARCH 6:50AM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL MANOR TALBOT EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 0CT 6,1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗶 F Months 91 Director 145-10-5908 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sl Examiner must be notified MD TALBOT EASTON X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 DUTCHMANS LANE 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by 3X Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) 12 College (1-4or 5+) nd Mental Hygiene. SECRETARY PRIVATE FAMILY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY C. MOORE CORA WILLIS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE R. BAYNARD/DAUGHTER 305 STARR RD., CENTREVILLE, MD 21617 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State permit. Page Department o Important: If any Injury or once. CHESAPEAKE CREMATION CTR 3/16/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 MHOL MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Res /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Di (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe 1∏ Yes 2 No e Hospital or Attending Physician: 24 hours after death. 9 Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 | Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 WILLIAM H. WOOD M.D., 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Re strar's Signature State Registrar

			1 - For State Registrar	State of Maryla		artment of H rtificate of I			ene 0 0 8	10818
			Decedent's Name (First, Middle, La	st)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Death		3. Time of Death
	Physici /Medio			Agnes E. Russ	ell			Month March	20 2008	12:30 A ^M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	
			5460 Ruth Keeton	Way		Columb			Howard	
	Funeral		5. Social Security Number 6. S	ITIM MOTE	rs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		214 22 1332 Usual Residence of Decedent	83	115.			Aug 21,	1924 Ma	ryland
	yland Fow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	a-f et	tor	MD Howard	C	olumbia					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a		5460 Ruth Keeton	Way		2104	4		United St	ates
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "neture!, or items 23a or 28a-f show sty injury or other treumatic event, the Medical Examinating the notified at ODGs.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🛣 No	10.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
38	irs aff	by F	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐Yes 2XNo	Specify:		Specify:	White
Š	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business	
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	ed wi	် ပ	12		Ho	memaker			Own Home	e
nd	be fill d off	Be	17. Father's Name (First, Middle, Last Norman T. Owens)				ne (First, Middle, M	aiden Sumame)	
Maryland	ould d Mer narke	7		Tree Brief	40h M-11	- Add (C44	Agnes M.		City on Town Chain	Zio Co do l
Ma	d 2 sl th and 17 te r treur		19a. Informant's Name/Relationship (1				City or Town, State,	Zip Code)
	Heal Heal tem 2		Kelly Russell/Son 20a. Method of Disposition		. Place of Dispe	Lambeth Rough of Control of Contr			Oc. Location - City or	Town, State
OE.	Pages ent of nt: if i		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Contr			matory or other place 11e Vet Co	1	5-2008	Crownsvil	le MD
Baltimore,	mit. F portar portar / inju		21. Signature of Funeral Service Lice	4 17						mily FH Inc.
m	Depa Impo		> Shem Collins	-ally by						, MD 21043
			23a. Part1. Enter the disease, or corr shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 1/00504	esic					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
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	axecu al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
38760,	icate be executed physician and s the burial-transit	dical		d						
_		63								
Box	eath certific attending pl for use as I	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		Ectopic pregnancy			23d. Date of de	•
P.O.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
	that the	Ph	Part II. Other significant conditions of	contributing to death but not	resulting in the u	inderhing cause aw	on in Part I	23e Did tobs	acco use contribute t	o the cause of death?
ds,	signe d be	d by	Tarin one organical contained	Similaring to death but not	resolding in the t	indeniying cause givi	att itt r att i.	1 🗆 Yes		robably 4 DUnknown
Ö	w require been sl	ete						24a. Was an		utopsy findings available
Be	The lav	Completed						autopsy perform	ed? prior to death?	completion of cause of
ā	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 th (Check only one		3 2 □ No
\leq	G 5	ToB	examiner? 1 ☐ Yes 2X No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth			ice 6 ☐ Other (Spe	ecify)
0	ding Ph h. After th funeral		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o		at k?	28d. Describe how		
Sio	r Attending er death. rector: After by the fune	catle	2 Accident investigatio	n			Yes 2 □ No			
Division of Vital Records,	2 2 2 2	Certification:	4 Homicide determined		t home, farm, st ecify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	oepital hours a unerai [ly filled		29a. Certifier	ysicien: To the best of my l	raculadas dant	the constraint at the time		and due to the sec	(2)	
	24 ho	Medical	(Check only 2 Medical Exer	niner: On the basis of exam and manner stated.	ination and/or in	ivestigation, in my o	pinion, death occur	rred at the time, dat	e and place, and du	e to the cause(s)
	Po the Hospital of within 24 hours at To the Funeral Completely filled it	Me	29b. Signature and title of certifier	1 /	/ /	29c. License		1	d. Date signed (Mon	
/			1 /fm	11, ha C	1 M	1	3876.	2	March 20.	2008
(30. Name and address of person who	mpleted cause of death (I	tem 23a) (Type,	Print)	5411 01	d Fred	ericle Rd	- Suite 18
	EG,		Sharm	J. /1/2 601	made	MD	Bultim	ore, Ma	. 2/12	2008 - Soik 18 9
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1	2008 32. Refristrar's Signature	gnature	Societ a		,		
	negistr			- Journa	1	The same				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 2:00 **Physician** March 20, Roselie Lee Russell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's 38664 Vanward Road Abell If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🔀 F 55 212-66-2739 7/1932 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ∐Yes 2 X No Funeral Director St. Mary's Abell Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 38664 Vanward Road 20606 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give XX Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Waterman Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredrick Gray Roberta Lee Lyon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lee Russell, Sr. /Husband 38664 Vanward Road, P.O. Box 241, Abell, Maryland 20606 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o I 🙀 Burial 2 □ Cremation Sacred Heart Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 24, 2008 Bushwood, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee Helias P.O. Box 270, Leonardtown, Maryland 20650 23a. Part . Enter the disease, or comshork, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) stu /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed after death. and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 23e. Did tobacco use contribute to the cause of death? þ Completed

certificate has been si rector, page 2 should neral Director: /

Be

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Certification:

Medical

4 Homicide

(Check only

29a. Certifier

one)

1 □ Yes 2.■No 9 □ Unknown	4⊔Pregnant at time of death 9□Unknown	5 ☐ Other (specify)
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Pa

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

	g,g g
25. Was case referred to medical	26. Place of Death (C

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one)

examiner?	No	Hospital:	1 ☐ Inpatient	2 🗆	ER/Outpatient	
27. Manner of Death 1 ☑Natural 2 ☐ Accident		28a.	Date of Injury (Month, Day Ye		28b. Time of Injury	
3 ☐ Suicide	6 Could not be determined	e 28e.	Place of injury	At h	ome, farm, stree	

Other: 4 Nursing Home 5 AResidence 6 Other (Specify)

fonth, Day Year)	Injury		Work?		28d. Describe now injury occurr
		M	1 ☐ Yes	2 🗌 No	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3□ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) Lizertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of ce	ertifier
1/1	1
	>3

29d. Date signed (Month, Day, Year) D62042

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28103 Three Noteh Rd

Karen ND 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 24 2008

State Registrar

To the Hospital of within 24 hours at To the Funeral D

arry Snulley	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2008 108
Physician Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day Year
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2300 blk Otterdale Mill Road Taneytown 4c. County of Death Carroll
Funeral Director	5. Social Security Number 218-46-2611 A Months Days Hours Min. Social Security Number 218-46-2611 A Months Days Hours Min. Social Security Number 218-46-2611 A Months Days Hours Min. Social Security Number 24Hrs. Soc
Varyland 28a-f show any d at once.	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
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5-0036 ed within 72 hour lygene. other than "natu the Medical Exan	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Security Guard College (1-4 or 5+) Security Guard 16b. Kind of Business/Industry 16b. Kind of Business/Industry Security Security
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after trent of Health and Mental Hygene. Iant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Commised by	Louis D. Shulley Louise Ellen Needy
MD 21 nd 2 should salth and Me salt 27 is ma raumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Woerner, sister 1140 Carroll's Tract Rd. Orrtanna, PA 173 rd. 20a. Method of Disposition 120b. Place of Disposition (Name of cemetery, Date 120c. Location - City or Town, State)
Baltimore, MC permit Pages 1 and 2 st Department of Heath an Important: If item 27 injury or other trauma	1 XX Burial 2 Cremation 3 Removal from State Fairfield Union Cemetery 4 Donation 5 Other Specify: Crematory or other place) Fairfield Union Cemetery 3-29-2008 Fairfield, PA
	Delia Lee Davis Mol414 J.L. Davis Funeral Home Smithsburg, Md. 21783
Physician /Medical xaminer	23a_Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Death Due to (or as a consequence of):
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uted nd ransit Fxaminer	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.
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x 687 h certific tending p use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
res that the deat signed by the att be detached for the Dryes	1 Yes 2 No 3 Probably 4 Vunknown
of Vital Records, and Physician: The law requires of the this certificate has been signeral director, page 2 should be not To Be Completed.	24a. Was an autopsy findings available autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Reician: The scertificat	25. Was case referred to medical examiner? Located: 26. Place of Death (Check only one)
C# _ ~ ~ 6	27. Manner of Death 1 Natural 5 Pending 128a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 No Poil
or At Or At Office Office of the by	2 Macident Investigation 3 Suicide 6 Could not be determined Could not be dete
Di To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 24, 2008
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	
DHMH 17 Rev 1/2001	ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles Leroy Stevens **Physician** Month Day Year March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital @ Easton Talbot taston 8. Date of Birth (Month, Day, Year) 8 - 8 - 1931 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 308-28-8241 Months Days Hours Min. 1**X** M 2□ F Chicago, Il. 76 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the M. dical Examiner must be notified at Director Bozman X Yes 2 No Talbot Md 10e. Street and Number 22481 Inc 10f. Zip Code 10g. Citizen of What Country? Indian Pt. Rd. 21612 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Y Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married ²□\Army 1 ☐ Yes 2 📉 No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years College Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Phillip Stevens Rosalie Dennis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Gardner Stevens (wife) 22481 Indian Pt. Rd., Bozman, Md. 21612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Capitol Crematory 3-7-2008 Dover, De. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Carroll Hurley Funeral Home, 21. Signature of Funeral Service Licenses O. Box 518, St. Michaels, Md. P 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) mediate Cause (Final Physician /Medical Due to (r as a consequence of): Examiner irchar Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Exam Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: esn. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) ed by the a detached f 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated by the second of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has lirector, page 2 s autopsy perform rmed? 2 X No 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 🕅 Inpatient ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) he Hospital or Attending Pl n 24 hours after death. he Funeral Director: After the pletely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

death certificate be executed Box 68760 P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

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DHMH 17 Rev 1/2001

completely

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Signature and title of certific

29a. Certifier

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(Check only

S. WAShmith 8t 219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

m 1993

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For		State of	of Maryla		artment of			lental Hy	giene			
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es 1 a of He of He rothe		20a. Method of Disp		2 Domewal from	20b.	Place of Dispo	osition (Name of matory or other pl	ace)	С	Date	20c. Lo	cation - City or	Town, Sta	ate
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Fu	neral Service	Licensee	1	G^2	2. Name and Add	ress of Fac Cre	matio:	n Servi	.ce	P.O. Bo	x 78	4
TU = 60	\vdash	220 Parts Enter th	ly L	complications that	MO MO	1251 Be	everly L	Hec	krotte	e, P.A.	Cla	rksv i ll		
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or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determi	ined 28e. Place	of injury - At h ing, etc. <i>(Sp</i> ec	iome, farm, sti ify)	reet, factory, office		2	28f. Location (3 City or Tox		d Number or R	ural Route	Number,
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Vith vith Con Con	Σ	29b. Signature and title of certifier MD	29c. License r	,		9d. Date signed (Mon	th, Day, Year)	
		*	NOO.	5463	0	March 10	, 2008	
12		30. Name and address of person who completed cause of death (Item 23a) (T						
Sta	to	Syed W. Haque MD 700 Montclaire Ave 31. Date filed (Month, Day, Year) 32. Registra Signature	enue, Freder	ick, Mar	yland 2	1701		
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State of Maryland / Department of Health and Mental Hygien 🗸 🖰 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Year 11:49 QM **Physician** 2008 John Scott Shannon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Haure de Grace

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months Days | Hours | Min. | Sept. 23, 1 Harford Memorial Hospital Harford 5. Social Security Number 9. Birthplace (State or Foreign Country) 1921 MaryLand 7. Age (In yrs. last birthday) **Funeral** 1∭ M 2□F 86 Director 216-14-1005 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than 'natural', or items 23e or 28e-f ahor 'traumatic event, 'na Medical Examples must be notified as 1 Yes 2 □ No Maryland Harford Havre de Grace Funeral Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 421 N. Freedom Lane 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1941
If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: δ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther Mary O'Baker John William Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health itam 27 Jim Gilbert (Son-in-Law) 209 N Union Ave Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important: If iter
any injury or ott 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) |Harford Mem. Gardens | 3/27/2008 | Aberdeen, Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service License 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA **Physician** /Medical Due to (or as a consequence of): Examiner nyocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 1 ☐ Yes 2 ☑No s effer deau... ral Director: After this cerum... 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled i 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier D0065827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Poppe 31. Date filed (Month, Day, Year) ucmo 32. F Spistrar's Signature, State

Registrar

3/24/08

gohn

Shannon,

Box 68760,

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Division of Vital Records,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MARCH BEIIT.AH SCHULTE T. 14, 2008^a 0510 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON TALBOT WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. DEC. 05, 1919 9. Birthplace (S Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 492-16-0557 88 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1x Yes 2 □ No MD. Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 10 1 ☐ Yes 2 No WHITE Specify: \$ 3 ₩idowed 4 Divorced "natural", Completed er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than other traumatic event, the M HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY SALINGER HATTIE RISKE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other to KAREN M. FISHER/ DAUGHTER 7614 EASTON CLUB DRIVE, EASTON, MD. 21601 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ARLINGTON NATIONAL 4 □ Donation 5 □ Other (Specify) ARLINGTON, VA. 4/15/2008 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 21. Joseph 200 S. HARRISON ST. EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse Examiner Sequentially list conditions, if any localing to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury after death. 1 Tyes 2 TNo 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State

ROBERT B. SANCHEZ ^{Ye}1 8 2008 Registrar

29b. Signature and title of ce

508 IDLEWILD AVE., EASTON, MD 21601 M. D 32. F

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Herbert 12:40 AM Linwood 03 Sampson 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mallard Dorchester Bay Nursing Home Cambridge If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F 62 217-42-7469 Maryland 09-06-1945 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Md. Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 105 Camelia Circle 21613 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never worked 12 Never worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Sampson Naomi Camper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camper / Brother 628 Jacks Lane, Federalsburg, Md. 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State Petersburg Cem. 4☐Donation D Other (Specify) Hurlock, Maryland 03-18-08 22. Name and Address of FacilitBennie Smith Funeral Home 21. Signature of runeral Service Licensee 516 S. Main Street, Hurlock, Md. 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ling Carcer Metastata Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to (or as a consequence of)

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: if item 27 is marked other that any lijury or other traumatic event, the long.

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Hygiene. other than "natural", or items 23a or : ent, the Medical Examiner must be r

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

certificate be executed and burial-trar physician certificate To the Hospital or Attending

Division or Vital Records, P.O. Box 68760

Lause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):				
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3 ☐ Suicide 6 ☐ Could no determin		nome, farm, street, factor	y, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.					
29b. Signature and title of certifier	Mile ven	29	c. License number	29d	. Date signed (Month	, Day, Year)

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CAMBRIDGE

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State Registrar

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31. Date filed (A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	/Medic Examin		4a. Facility Name (If not institution,		mber)		4b. City, Town,	or Location	of Death	riar cii		County of Deat		10 11
	LAGIIIII	C1	1118 Old Westmi				Westmin	ster			Ca	arroll		
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	the 128a-	rect	MD Carro1 10e. Street and Number	.1	wes	tminste	10f. Zip Code			T	10g. Cit	izen of What Co	untry?	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician 14, 2008 4c. County of Death : 40 PM ermon /Medical March 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numi Examiner Dorchester Security Number 6. Sex 4 Hrs Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Hours Months Days 1 ■ M 2 🖭 215-12-646 Nov. 29, 1923 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show be notified at 1 Yes 2 No Director ambri archest 10e. Street and Number 10g. Citizen of What Country? 0 2/6/3 items 23a US Completed by Funeral treet Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Moo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 □ Divorced Black Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seasonal 10 Cannery Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henri ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave, Fort Myers, F(3)
Date | 20c. Location - City of Town, State the 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
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Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ordtown Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of F. cility

Henry Funeral Home I

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23a. Patt. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final noundh **Physician** ue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (pr as a consequence of) Examiner The law requires that the death certificate be executed ev that initiated events resulting in death) Last and Due as a consequence of) burial-P.O. Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Day signed by the a d be detached for 5 ☐ Other (specify) 9□Unknown 9∏Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 I I Inknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l autopsy perform certificate amous 2 No or Vital To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 3□ DОА 1 Inpatient 2 ER/Outpatient Certification: To this 27. Manner of Death within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a, Certifier 1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signate 8 deddress of person 30. Na who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Month, Day, Year) egistrar's Signature State 2008 AR 1.8 Registrar

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31. Date filed (Month, Day, Year) MAP 2 1 2008

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32. Registrar's Signature

65C THOMAS UDHASSIN

FREDERICK Z1702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 March 18, **Physician** Charles Ralph Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 24,1924 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1∭ M 2□ F Director 216-20-7556 83 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other tranmatic event, the Meclical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Frederick Mount Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12461 Jesse Smith Rd. Completed by Funeral 21771 United Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Family farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be W. Smith Mary Virginia Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12461 Jesse Smith Rd./ Mount Airy, MD Louise E. Smith / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Mount Olivet Cem. 103/22/2008 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part1. Enter the dise shock, or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) O. Box 68760, physiciar Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed? certificate or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Division or After this 27. Manner areath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 atural 5 ☐ Pending М 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined filled in by 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12:35 P.M

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2X No

Approximate Interval Between Onset and Death

Year

Day

Maryland

States

White

29a. Certifier (Check only one) 29b. Signature and title of certified

🖎 Ifyling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

2008

Registrar DHMH 17 Rev 1/2001

State

completely

Medical

Hospital

■ Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		Please	e Type or Prin	it in Black In	delible Ink.	Ensure A	II Copies	Are Legible.	
		. For	State of Ma	aryland / Depa	artment of H	lealth and N	lental Hy	giene	
		1 - State Registrar		Cei	rtificate of I	Death		Reg. No. 2	10831
Phys	sician	Decedent's Name (First, Middle, I	ŕ				Date of Dea Month		3. Time of Death
	edical			Ann Staup			Ma	arch 26, 2008	5:00 A ^M
Exa	miner	4a. Facility Name (If not institution, g		-1. 0	4b. City, Town, or	r Location of Death		4c. County of Dea	
Fune	und l		Nursing and Reh	ab Center e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	coning 8. Date of Birt	h 0 Riv	Allegany thplace (State or Foreign
Direct		217-10-4637	1 □ M 2 💢 F	91 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) C ry 22, 1917	West Virginia
p.		Usual Residence of Decedent		10.00					
aryla show	7	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🕱 No
the M 28a-f notifie	Director	Maryland A	Allegany		10f. Zip Code	Lonaconing		10g. Citizen of What C	121
with 3a or t be			er Georges Creek	Road	Tot. Zip Gode	21539			J.S.A.
death ms 2:	Funeral	11. Marital Status	12. Was Decedent B		Was Decedent of H If Yes, specify Cuba		pecify Yes or No		erican Indian,
after or Ite mlnei	교	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	ło	1 ☐ Yes 2 🛣 No	an, Mexican, Puerto Specify:	Hican, etc.)		
nours ural", I Exa	d by	3 M Widowed 4 □ Divorced	Year or Dates:					Specify:	White
ר27 ו "nati edica	lete	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	king	16b. Kind of Business	/Industry
withii iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	20 770 7 400 7011700	" Cook		С	afeteria
il Hyg other	Be	17. Father's Name (First, Middle, La				18. Mother's Nam	e (First, Middle,	Maiden Surname)	
uld be Menta Irked tic ev	P		George Brask	ey			(Ora Cheponis	
2 sho and I Is me		19a. Informant's Name/Relationship	, ,,		-			er, City or Town, State,	• •
l and lealth im 27	146	Michael S 20a. Method of Disposition	Staup - Son				Date Date	onaconing, Ma	
реттіt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		1 X Burial 2 ☐ Cremation 3			osition (Name of matory or other place n Memorial C		March 31,	20c. Location - City of	e, Maryland
iit. Pa artmei ortant Injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic					2008		
Deperment Deperment of the perment f the perment of the permet	ouce	In & Mik	50	-				neral Home P.A	
		23a. Parl 1. Enter the disease, or ock, or heart failure. List on	mplications that caused	the death. Do not ent					Approximate Interval Between
Physicia	an 🔻	Immediate Cause (Final disease or condition	•	inuma o	+ bile	a de	1		Onset and Death
/Medic	al	resulting in death)	Due to (or as a	a consequence of):	01114	- Jane			372045
Examin		Sequentially list conditions,	b						
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):					
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):					
te be (/siciar e buri			_d						
The law requires that the death certificate bate has been signed by the attending physicoage 2 should be detached for use as the b	Physician/Medical	I FEMALE							
th certendir	an/N	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p		□Ectopic pregnancy	,		23d. Date of de	•
ne dea the at	/sici	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			Month	Day Year
w requires that the death cer been signed by the attendin should be detached for use	Ph.	Part II. Other significant conditions	s contributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
luires sign lid be	d by	Athenscle	atic Coros	any Arte	7 Dise	a SC	1 🗆 🗅	res 2. No 3 □ P	robably 4 Unknown
aw rec	Completed	Chronic	rtic Coron Renal I.	a cuffic	ciency		24a. Was	an 24b. Were a	utopsy findings available
The lav	m o						autor perfo 1 Yes	prior to rmed? death? 2 No 1 □ Yes	completion of cause of
ian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat			3 2 140
Physician: The la this certificate ha ral director, page 2	2	1 ☐ Yes 2 ☐ Mo		nt 2 ☐ ER/Outpatier		4 Mar Hursing Ho	ome 5 ☐ Resid	dence 6 □Other (Spe	ecify)
ling F After funera	ü	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injur (Month, Day		Worl		28d. Describe h	now injury occurred	
death ctor: y the	icat	2 Accident investigati 3 Suicide 6 Could not	be Diago of inju	ry - At home, farm, str		Yes 2 No	28f Location /5	Street and Number or F	Jural Route Number
after I Dire	Certification:	4 ☐ Homicide determine	building, etc	(Specify)	oot, ractory, orner		City or Tov	vn, State)	urar rioute Number,
bours hours unerally filler	ia O	29a. Certifier 1 Certifying I	Physician: To the best o	of my knowledge, deat	h occurred at the tir	me, date and place,	, and due to the	cause(s) and manner a	s stated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director, f	edical	one)	raminer: On the basis of and manner sta	ted.			rred at the time,	date and place, and du	e to the cause(s)
Vith To		29b. Signature and title of certifier	0	2	29c. License	e number		29d. Date signed (Mon	th, Day, Year)
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	2	1 / Ku	uf Oli	olii 48	0.	21488		March 26	1008
	5	30. Name and address of person wh	no completed cause of de	eath (Item 23a) (Type,	Print)	21488	/	March 26	1008
	5 State	30. Name and address of person when Thomas I Day (31. Date filed (Month, Day, Year)	12 MD 20	eath (Item 23a) (Type,	Print) Avenue,	Longe.	nng, 1	Markland, a	1539

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician 2008 Month Day Lane larr March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Hospita nestertown ant Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days 214-46-4739 Director 60 MARYLAND JAN 14,1948 Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 29276 HEWORTH ROAD Funeral 21601 TISA iral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Be Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 DESIGNER FLORAL marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any liury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ CALVIN GRASON HORNEY MILDRED ESTHER HOXTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION E. TARR/HUSBAND 29276 HEWORTH ROAD, EASTON, MD 21601 saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 █ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY: 3/18/2008 | EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Tue to (or as a consequence of): spilaleng disease or condition resulting in death) /Medical Examiner Ration Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Muscular Sistrophy physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 Yes 2 No 3 Probably 4 Unknown been si should I Completed page 2 s PERMITERT PHEMAKEN 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy perform **Division or Vital** 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after

State

MAR 1 4 2008 Registrar

29a. Certifier

John

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

e. AMMABAL 223 Hogh Street, CHertertown, Wed 21620 32. Registrar's Signature

Mr. M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Funeral 24 hours

To the I

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day} Month 2008 Year **Physician** Olive Travers Truitt March 1:55 p. ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 922 Hudson Road Cambridge Dorchester 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 214-46-4544 85 Director 27, 1922 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 'natural", or Items 23a or 28a-f show di.al Examiner must be notified at MD Dorchester Cambridge Director 1 ☐ Yes 21 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 922 Hudson Road 21613 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or large any injury or other traumatic events. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐No Specify: white þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Vernon Travers Alice Pauline Creighton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton J. Truitt Jr. son 307 Sandy Hill Road, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spedden Seward Cem. 3/22/08 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl o e Other: 4 Nursing Home 5 PResidence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 ☐Other (Specify) 27. Manne of Death funeral 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

State

29b. Signature and title of certifier

BRIENDON

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Awora

29c. License number

Cambridge

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 3:10 2008 Mary Theresa Thompson March 24. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 16,1949 9. Birthplace (State or Foreign **Funeral** 58 Months 212-54-5181 Yrs Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland St. Mary's Avenue 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23188 Coltons Point Road 20609 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic. Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Walter Lacey Minnie Margaret Farrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Lacey / Brother P.O. Box 97 Avenue, MD 20609 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State March 27, Sacred Heart Cemetery Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A P.O. Box 270 Leonardtown, MD 20650 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a Date of Injury 28h Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jarboe, M.D. James P. 24035 Three Notch Road Hollywood, MD 20636 31. Date filed (N h, Day, Year) 32. Registar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #4b, 4c, 3-19-08, per Freekrificate of Beath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5:00 A^M 2008 Cottie E. Whitener March 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner -Laurel Howard 10533 Martellini Drive Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Apr 28, 1 Days Hours 1 M 2 VF 242 01 9647 94 1913 Director North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d, Inside City Limits 28a-f shov notified at 1 Yes 2 No Director Howard Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 10533 Martellini Drive 20723 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: . þ 3 Widowed 4 □ Divorced White er than "natur ; the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental H Alfonzo Cooke Eliza Jane Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun Clyde A. Whitener, Jr./Son 10533 Martellini Drive Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gard. 3-22-2008 | Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc, 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DEMENTIA YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: for use a If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ eg MZIGIOSYHTOGYH DAIW FACIAL 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate 2**X** No Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2**X** No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c, License number 29d. Date signed (Month, Day, Year) 138296 March 18, 2008

DHMH 17 Rev 1/2001

State

Registrar

8186 LARKBROWN ED, SUITE ZOI, ELKRIDGE, MJ ZIOFS

ess of person who completed cause of death (Item 23a) (Type, Print)

32. **Ge**gis

Registrar's Signature

G1330:45

2008

10f. Zip Code

16a. Decedent's Usual Occupation

1 ☐ Yes 2 X No Specify:

21403

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

U.S.A.

14. Race - American Indian,

White

Black, White, etc.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene and Propertment of Health and Mental Hygiene and Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Exami

Physician/Medical

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Completed

Be

Certification: To

Medical

10e. Street and Number

11 Marital Status

774-A Fairview Avenue

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3€XWidowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 No
If Yes, Give
Year or Dates: ₩₩ II

Funeral

Director

Physician /Medical Examiner

are locari.

Director: After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

(Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Equipment Leasing Vice President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur E. Webster, Sr. Emma Becker 19a. Informant's Name/Relationship (Type. Print)
Kim Miller/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Aldridge Court Sterling, Virginia 20165 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore Crematory 4 □ Donation 5 □ Other (Specify) 3/16/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure 1 month Due to (or as a consequence of): Coronary Artery Disease 14 years Sequentially list conditions Diri to for sele consequence of: train, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aortic Stenosis Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 250N 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home STResidence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45297 March 13, 2008

OH CH State

e Funeral

31. Date filed (Month, Day, Year)

Elaine Arata, MD

MAR 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31 Robinson Road Severna Park, Maryland

32. Figistrar's Signature

DHMH 17 Rev 1/2001

Registrar

2008

USA

TALBOT

MARYLAND

WHITE

OTUA

Month

1 ☐ Yes

Dav

3 ☐ Probably 4 ☐ Unknown

2 No

Year)

Year

0847 AMM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra DHMH 17 Rev 1/2001

State

DAVID SMITH M.D. 8221 TEAL DR., SUITE 302, EASTON, MD 21601

32. Registrar's Signature

08-02129)
Rertha I	\//right

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

sertna L. vvrignt	State of Maryland / Department of Health and Mental Hyglene 1- For State Certificate of Death Reg. No. 2008 003
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Medical Examine	Bertha L. Wright March 16, 2008
	4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Dorchester General Hospital Cambridge 4c. County of Death Dorchester
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Mary Land
Director	214-10-0889 1 M 2 X F 86 Yrs. 1/30/1922 Country)
, any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
f show	Maryland Dorchester East New Market 1 X Yes 2 No
the Maryland a or 28a-f sh tifted at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
death with the Maryland or items 23a or 28a-f show must be notified at once.	1912 Academy St., Apt. 205 21631 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
or items 23: must be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
s after or niner m	3 Wildowed 4 A Divorced if tes, close tear 1 Yes 2 1 No specify: Specify: WILL CE
hours natur Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Bookkeeping Bookkeeping
5-00 led wit tygien other	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
11215-0036 Id be filed within 72 hours after dental Hygiene. Tarked other than "natural", event, the Medical Examiner.	John Keplinger Lydia Scherch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1D 21 2 should and Mer 27 is man matic ev	Karen Rayne/Daughter 905 Kathleen's Terrace, Salisbury, MD 21804
e, N I and I Health item	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
MOF Pages ent of init: If	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: MidShoreCremationCenter Cambridge, MD
Baltimore, MD 21215-0036 pemit. Pages I and Sabuild be filed within 72 hours after death with the Maryland Department of Health 2nd Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licens 22. Name and Address of Facility Mid. Shore Cremation Center PO Box 1464
Physician	Approximate interval
/Medical	failure. List Try one cause on each line. Immediate Cause (Final disease a. Multiple Injuries Between Onset and Death
⁻xaminer	or condition resulting in death) Due to (or as a consequence of):
<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
i.i.	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):
n and transit al Ex	d.
60, are be executed hysician and e burial - transit	UNPENDED AMENDED
cox 68760, eath certificate be exe attending physician for use as the burial-for use as the burial-for ician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
). Box 687 the death certification by the attending people for use as the Physician//	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
), Bc the des	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
, P.O. res that signed to be detailed by	1 Yes 2 ✓ No 3 Probably 4 Unknown
w requir	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Records, The law requires ficate has been sig	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recc vysician: The lav his certificate ha director, page 2	25. Was case referred to medical 26.Place of Death (Check only one)
F Vit	1 V Yes 2 No Impatient 2 V ENOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:
Division of Vital Records, P.O. spial or Attending Physician: The law requires that the nours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Commisted by P.	27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28d. Descr
Visic or Atte frer des jirecto in by ti	2 Accident Investigation Mar 16, 2008 1118 hrs
Division Spital or At Spital or At Cours after de neral Direct filled in by Cortifics	4 Homicide determined (Specify) Major Road / Highway Rt. 50 & White Hall Road , Cambrigde, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Re Completed by Physician/Medical Es	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
7 × 15 × 15 × 15 × 15 × 15 × 15 × 15 × 1	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
,	O.C.M.E. March 17, 2008
0	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat	31. Date filed (Mooth, Day, Year) 32 Registrar's Signature
Registra	The state of the s

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 45 AM Vera Mae Whisner Marc 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Cumberland Lions Center Rehab | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 28 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 232-48-2001 1 □ M 2 🛣 F 76 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10b. County 10d. Inside City Limits 10a State WV. Mineral Ridgeley 1 Yes 2 No 28a-f sh notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be 20 Pine St. 26753 United States ", or items 23a on aminer must b Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white \mathcal{U}/\mathcal{U} SRBY, $\mathcal{V}_{e^{\mathcal{N}}\mathcal{Q}_{e^{\mathcal{N}}}}$ Baltimore, Maryland 21215-0036 1 ☐ Yes 200No Specify. Completed by 3√2 Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than "natu aumatic event, the Medical Housework Elementary/Secondary (0-12) College (1-4or 5+) Homemaker unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Marple Metcalf Mary ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol McAvoy/ daughter RR 4, Box 48, Ridgeley, West Virginia 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 03/29/ 1 Burial 2 □ Cremation 3 □ Removal from State Keyser, West Virginia Potomac Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home Wa 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 XNo Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 1∐ Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mochile

Registrar
DHMH 17 Rev 1/2001

State

Bishop Walsh Dr. Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 2

MD C35 32. Registrar's Signature

Please Type or Print in Black indelible ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year JOSEPHINE CATHERINE ANTHONY MARCH 28 2008 5:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Crofton Convalescent Care Center Crofton Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 917 5. Social Security 700 Fer **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 182-16-4458 1 □ M 2 🖺 F 91 Director Pittston, PA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at Director MD Abingdon 1 ☐ Yes 2√∑ No Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Tiree Court 21009 USA Iteme 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Completed by Specify: White 3 XWidowed 4 ☐ Divorced natural', 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Kufta Anna Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i 311 Tiree Court Abingdon, MD 21009 John Anthony/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cemetery 4/2/08 4 Donation 5 Other (Specify) Brook Park, Ohio 21. Signatur of Funeral Service Licensee Name and Address of Facility Kolodiy-Sobczyk Funeral Home 3136 W. 14th Street Cleveland, OH 44109 23a Part I Enter the disease, or complications that caused the shoot or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician ou bro vase /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ď Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has lifector, page 2 s 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 1 Datural Injury 5 Pending within 24 hours after death. To the Funeral Director: A filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

P.O. |

Registrar's Signature

Sw Ola Burnie MD 21061

Emili Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** Emilia Henriques Almeida 2008 12:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) NOV • 16 , 1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 150-70-9857 1 □ M 2 1 F 86 Portugal Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if fisen 23a or 28a-1 show limportants if fisen 27 Is marked other than "natural", or Items 23a or 28a-1 show any InJury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore County Cockeysville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 25 Bosley Ave. Portugal Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. Specify: Portuguese 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home N/A Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lasalete N. Almeida Jose H. Silva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maria H. Henriques (Daughter) 25 Bosley Ave. Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 05, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem.Gard. 2008 Timonium, Maryland 4 Donation 5 Dother (Specify) eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses 23a. Part / Enter tile dis shock, or heart fail Immediate Cause (Final Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been s', page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate? completely filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) n 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Sign State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 0 DICE MOULUM Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country)

OALTI MORE, NO 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Min. -280 SYrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the Medical Evantiner must be multiple at 1 Yes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 1 Yes 2 \(\) No
1 Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working A life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last, Pages 1 and 2 should be f nent of Health and Mental ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trains 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Restry Evans runeral Chapel - Crema 23a. Part 1. Enter the disease, John dication, that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, shock, or heart falure. Limit on each line. rkville Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ESOPHAGEAL CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and defached for use as the burlal-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-02353 Marlyna Abrams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10843

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		Johns Hopkins Hospital				Aller R Date of Birth/	MM/DD/VVVVI q I	Birthplace (State or Foreign
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under	r 1 Year If Under:	Min /		Country)
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Records, P.O. Box 68. The law requires that the death certificate has been signed by the attending page 2 should be detached for use as the standard of the standard by the attending page 2 should be detached for use as the standard by th	Ē	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyi	ng cause given in Pa			ite to the cause of death?
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ivision or Attend after death. Director:	iga	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, street, fact	ory, office building, e	etc. 28f. Location (or Town,	Street and Number State)	or Rural Route Number, City
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Division of Vital By To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	꺜	20a Certifier	an: To the best of my knowledge	ge, death occurred at	the time, date and p	lace, and due to the cau	se(s) and manner a	s stated.
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To To con	ĕŀ	29b. Signature and title of certifier	and manner stated.		29c. License numbe			d (Month, Day, Year)
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1%	1	30. Name and address of person who	completed cause of death (item of Medical Examiner	111 Penn Stree	t, Baltimore, MI	21201		
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, $_{
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Funeral Director		5. Social Security N 214-68-0	134	3. Sex 1	je (In yrs. la: 52	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 07/20/1	th y, Year)		place (State or Foreign
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or Attendin after death. Director: Aft I in by the fur	Certification:	1 Matural 2 Accident 3 Suicide 4 Homicide	5 Pending investiga 6 Could no determin	ot be 28e. Place of In		ne, farm, stre		lYes 2□No	28f, Location (: City or To		umber or Rur	al Route Number,
le Hospital n 24 hours le Funeral pletely filled	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis and manner s	of examination	vledge, death on and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and pla	d manner as	stated. to the cause(s)
To th within To th	Me	29b. Signature and	I title of certifier				29c. Licens	se number			gned (Month,	Day, Year)
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08-02460 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael J. Brooks 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day March 28, 2008 2050 hrs **Medical Examiner** Michael Jerome Brooks 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 7102 Columbia Park Road Landover If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Months Hours Davs Director April 3,1956 577-74-6513 1X M 2 F 51 Country Virginia Yrs Usual Residence of Deceden 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 X Yes 2 No 28a-f show "natural", or items 23a or 28a-f sho Examiner must be notified at once. Washington 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3874 V Street 20020 United States Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 X No Yes If Yes, Give Year Specify: Black 3 Widowed Yes 2x No specify: 4 X Divorced "natural", \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done within 72 hours pleted during most of working life, DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na nigury or other transmatic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+) 4 TechMar of Georgia Chief Operating Officer Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Cosby Gaither Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Howard Leroy Brooks/Brother 13013 Tamarack Road Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/03/2008 Brentwood, MD Fort Lincoln 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral-Service Licensee Jefferson Funeral Chapel 5755 Castlewellan Drive, Alexandria VA 22315 23g/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician een Onset and failure. List only one cause on each line Madical Death a.Exsanguination Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Erosion of Dialysis Fistula Sequentially list conditions, if any, leading to immediate ue to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed: signed by the attending physician and be detached for use as the burial - transit Physician/Medical AMENDED 23a, b, Pt.II, 27, 28a-f per ME g878 4/9/08 amh X UNPENDED Records, P.O. Box 68760, 23d. Date of delivery IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 Yes 2 No 3 Probably 4 V Unknown End stage renal disease Completed been : 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other, Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural Yes 2 X No Pending Fnd 3/28/08 <u>Bleeding from a dialysis site</u> Fnd 8:40p 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) To the Hospital or within 24 hours at To the Funeral D (Specify) Single family residence 7102 <u>Columbia Pk Rd. Landover.</u>MD 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

Carol Allan, MD

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 29, 2008

Registrar's Signati

OL V

and manner stated

Assistant Medical Examiner

OCME

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPMFADD perFH, 0378, 4/4/08 WS
State of Maryland / Department of Plealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gloria Mavis Brown March 31, /Medical 2008 12:45 P.M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Center Baltimore N/A 5. Social Security Number 216-98-6268 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 1分 F Director Min 82 Yrs. June 17, 1925 Kingston, Jamaic Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Baltimore Director Baltimore tXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 5200 Frankford Avenue 21206 2 should be filled within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No 3₺Widowed 4 Divorced Specify: Specify: Jamaican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Nursing Nurses Aide 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Augustus Anderson Roslyn Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selvena Kitson/ daughter 5200 Frankford Avenue Baltimore, Maryland 21206 item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) unk. Date Pages permit. Pages Department of important: if it 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 4□Donation 5 🗹Other (Specify)Entombment April 12, 2008 Parkville, Maryland 21. Signature of Funeral Service Licenses peacerul Address of Facility tives Funeral & Cremation Ctr., P.A. 12 2325 York Road Timonium, Maryland 21093 23a. P.n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner ASWD Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy 4☐Pregnant at time of death Month 5 ☐ Other (specify) Day 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has birector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 1□ Yes 2 No this certific al director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Certification: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 Yes the 2 🗆 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/01/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Worldrem Woods boat Sonte 201-MD2124 8813

DRMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 0 4

2008

Certificate of Death

Reg. No.

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Director death with the Maryland 7 is marked other than "natural" or Items 23a or 28a-f show traumaile event, the Medical Examiner must be notified at

Directo

by Funeral

Completed

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other trauma ic event, <u>tt</u>

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

APR 04

2008

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, burial-tran and physician the page 2 certificate or Attending Physician: this funeral After death. filled in by the within 24 hours after deatl To the Funeral Director: completely

1. Decedent's Name (First, Middle, Last)
Roy Franklin Brandon 2. Date of Death 3. Time of Death Day 2008 1, April 10:30 A.M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Harford County 2106 North Ridge Drive Bel Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 15, 1926 6. Sex 7. Age (In yrs. last birthday) Days 246-32-4133 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford County Maryland Bel Air 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 2106 North Ridge Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Ft. Lauderdale 12 Waste Water Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Price Brandon Janice Irene Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Paulette Little 2106 North Ridge Drive, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Forerst Hill, Maryland Apr.5,2008 Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air
3 Newport Drive, Forest Hill, Maryland 2050 21. Signaturé of Funeral Service Licenses Mbeily XW/OVIL 23a. Part1. Enter the dise se, or complete is sthat cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin II disease or condition resulting in death) CONCESIONE HOTOLT Due to (or as a consequence of): h BULLIANON Amin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). WINT NEW HPORNSIIN Due to (or as a consequence of): COPD IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 14 OF CUA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HPOLLIPIDOMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H40769 080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGOWY BELAN MO 21015 2227 OLD Emmonnen RD JUIPE DOHMETEN 31. Date filed (Month, Day, Year) 32 egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4.00 P M Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ba Himore atonsville atonsville ommons 8. Date of Birth (Month, Day, Year) 09-02-1929 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 📭 215-22-989 8 D.C Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Ves 2 No MIA Baltimore Completed by Funeral Director MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 228 N. Culver Street USA 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Black Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Porse Baskerville Solomon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abbotston Brown Himore, MD. 21218 703 lanya Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Cedar Hill Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Vaughn C. Gre 5151 Baltimore Vaus Balto-Md. 21229 Nati 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** V /Medical Due to (or as a consequence of) Examiner⁻ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{Yo} \) No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signt completely filled in by the funeral director, page 2 should be Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TMo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 5 Freeleick Rd. Coforsville, 1009

State Registrar 31. Date filed (Month, Day, Year) APR 0 4

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Registrar's Signature

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Physician /Medical Examiner

Physician

/Medical

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Medical Certification:

Division or Vital Records, P.O. Box 68760,

disease or condition resulting in death) Sequentially list conditions, if any, leading to lintine diate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consequence of): b. Lue to (or as a consequence of):	Cardo n	yoputh	d
resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		topic pregnancy ther (specify)		23d. Date of delivery Month Day Year
 9 ☐ Unknown Part II. Other significant conditions	contributing to death but not resulting in the unde	rlying cause given in Part I.	1 ☐ Yes	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
25. Was case referred to medical examiner?		26. Place of Dea	autopsy performed 1 Yes 2 1 1 2 2 1 2 1 2 1 1 1 1 1 1 1 1 1 1	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence	e 6 □Other (Specify)
27. Manner of Death 12 Natural 2 Accident 5 Pending investigati	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		factory, office	28f. Location (Street City or Town, S.	t and Number or Rural Route Number, tate)
	Physician: To the best of my knowledge, death or aminer: On the basis of examination and/or inves and manner stated.			
20h Signature and title of cortifier		29c License number	204	Date signed (Month, Day, Vear)

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30. Name and address of person who completed cause of death (item 23a) (Type, Print) Howard H Bond Mr

. Registrar's Signature

31. Date filed (Month, Day, Year) APR 0 4 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** DU J /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth F. Month, Bay, Yard 22 If Under 86 **Funeral** Counta anada 1 □ M 2 1 F Months Days 378-32-2619 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Owings Mills Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Canada 21117 9310 Groffsmill Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registerd Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Mary Hall Leonard Fyfe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9310 Groffsmill Dr. Owings Mills, MD. 21117 Coral Nichols - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory April 1,2008 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Fun ral Service Licens 21. Signature 11605 Reisterstown Rd. Owings Mills, MD. 21117 un ne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Phen Mp ue to (or as a conse pience of /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the l attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by a sign of the sign o 2 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an certificate has birector, page 2 s The 1 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3□ DOA 2 No 2 ER/Outpatient ဥ 1 🔲 Yes this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Certification: (Month, Day Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State APR 04 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary G. Burall 04-01-2008 2336 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hosptial Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02-01-1923 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland 85 216-12-8710 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4309 Pulaski Hwy 21017 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unit Clerk Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Scarlatta Concetta Bevicula 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May Wilson (Daughter) 209 Margate Lane Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-05-2008 | Fallston, Maryland Highview Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARdlovascular Atherosclerotic years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If Item 27 is marked other I

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To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral

State

Registrar

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier

and manner stated.

29c. License number

135522

1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

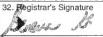
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTH

AVENUE BEL AIR MARYLAND 21014

31. Date filed (Month, Day,

2008





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year JUDITH BANNON ennet 0948 /Medical 2008 MARCH 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ■ M 2 🖫 F Months Days Hours Min Director 218-86-5346 Yrs. 42 Sept. 7,1965 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits Examiner must be notified at Directo 1 TYes 2 TNO Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 933 Elton Avenue Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o þ 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: Specify: "natura!", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 Years Disabled other N/A 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic ever John J. McGainey, Jr. ဥ Katherine Faulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : if item 27 is or other tra Melissa Webster (Sister) 613 S. North Pt. Road Baltimore, Maryland 21224 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Hilltop Service Corp. 4/3/2008 4 □ Donation 5 □ Othe
21. Signature of Juneral Serv 5 Other (Specify) Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory FAILURE 17 days /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 17days Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Winknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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filled in by the fu 2 Accident 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours a
To tha Funeral C

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29b. Signature and title of certifier

NICOLE J.HUNT



BALTIMORE, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MATCH 30, 2008

ORIGINAL

Medical Examiner Kristopher Kurt Cody Branamen 4a. Facility Name (if not institution, give street and number) 6920 Williamsburg Church Road Funeral Director Funeral Director Warch 31, 2008 4b. City, Town, or Location of Death Hurlock Funeral Director 5. Social Security Number 214-72-6247 1XM 2F 47 Yrs. Aug. 4, 1960 Maryla Usual Residence of Decedent 10a. State 10b. County Md. Dorchester 10c. City, Town or Location Hurlock 4b. City, Town, or Location of Death Hurlock Funeral Director 154 4c. County of Death Dorchester 47 Yrs. Months Days Hours Min. Aug. 4, 1960 Maryla 10d. In 10d. In 10d. In 10d. State 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10g. Citizen of What Country? 11SA	
Physician/ Medical Examiner Kristopher Kurt Cody Branamen 4a. Facility Name (if not institution, give street and number) 6920 Williamsburg Church Road Funeral Director Director Seg. No. 2. Date of Death Month Day March 31, 2008 4b. City, Town, or Location of Death Hurlock Hurlock Funeral Director 5. Social Security Number 214-72-6247 1 X M 2 F 47 Yrs. Months Day Hours Min. Aug. 4, 1960 Mary 1 aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In 10d	me of Death 540 hrs e (State or Foreign and Inside City Limits
Month Day Year 154	e (State or Foreign and Inside City Limits
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12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indi	ıdian, Black,
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indi White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indi White, etc. 17. Yes 2 X No specify: 18. Specify: White	1+0
Specify: While Spec	
during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)	
Solution of the contract of th	
Kenneth W. Branamen Bertha P. Van Horn	
Parametris Name/Relationship (Type, Print) September 19a. Informant's Name/Relationship (Type, Print) We neth W. Branamen/Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State 1 Burial 2 X Cremation 3 Removal from State 1 Burial 2 X Cremation 3 Removal from State 2 Crematory or other place)	
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	proximate Interval
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
Sequentially list conditions.	
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24a. Was an autopsy performed? 1	etion of cause of
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25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 ✓ Yes 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 2 No 1 ✓ Yes 26. Place of Death (Check only one) 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	ne
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29c. License number 29d. Date signed (Month, Date signed (Month, Date signed (Month), Date si	ay, Year)
April 1, 2008 30. Name and address of person who complete 'cause of death (flum 23a)	

Theodore M. Kíng, Jr., MD. Assistant Medical Examíner 111 Penn Street, Baltimore, MD 21201

62. Registrar's Signature

Registrar

State 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name 2. Date of Death 3 Time of Death **Physician** 08 /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1910 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😿 F IRELAND Yrs 100-42-6186 97 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 2 and 10 minury or other traumatic event, the Medical Examiner must hen reporce. 21212 6806 BELLONA AVE USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1.XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELLEN JOHNSON TIMOTHY BROSNAN P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3725 ELLERSLIE AVE. BALTO., MD. 21218. SR. JODEAN (P.O.A.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) CLARE COURT CONVENT 03/31/08 BALTO CITY, MD. 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111. 21. Signature of Faneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athoros clerotic (and o vasalar disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed after death. and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 031865 Inon-o 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bactimore N 821 Gutan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 4 2008 Registrar

08-02187 Jimmy Ray Carter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10855

		For State	-	Certi	ificate o	f Death					Reg. No.			
Physicia		ecedent's Name (First, Middle,Last) 2. Date of Dearn Month Day Year							Time of Death 1849 hrs					
~al Examin		Jimmy Ray Carter March 18, 2008							1040 1110					
	4a. Facility Name (if not institution, give street and number)					Prince George's								
	-			(In yrs. las	t birthday)	If Under		If Under	24Hrs.	8. Date of B	irth (MM/E	(YYYY)	9. Birthpla	ace (State or Foreign
Funeral Director		, , , , , , , , , , , , , , , , , , , ,	x M 2 F	68	Yr	Months		Hours	Min.	2-14-	-1940)	Countr	
		Usual Residence of Decedent												
Aaryland 28a-f show any d at once.		D i C									1	Yes 2 X No		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number								Country	?			
the M a or 2 tified	ä	17700 Aquasco E	arm Road			206	13					JSA		
1 with th ms 23a be noti	era	11. Marital Status	Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								Indian, Black,			
r death or ite	Funeral	Never Married 2 Married 1 X Yes 2 No							Wł	nite				
rs afte ural", miner	<u>a</u>	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work of								ork done	16b. Kind of Business/Industry			
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)							OO NOT use retired)					
5-0036 led within 7. Hygiene. I other than the Medica	힐	12 Mechanic Auto												
D 21215-003 should be filed within and Mental Hygiene. T is marked other the natic event, the Med		17. Father's Name (First, Middle, La	st)				1.		· ·		e, Maiden Surname)			
2121 hould be fill and Mental F is marked attic event,	Be	Harold Carter 19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street	and Numb	ba B berorR	ural Route N	umber, C	ity or Town,	, State, Z	ip Code)
MD 2 d 2 shou' Ith and N n 27 is n	۴	Roberta Chapma			7.					Ohio	456	623		
= 65 = 70	ı	20a. Method of Disposition		20b. P	lace of Disn	osition (Nam	ne of cem	etery,		Date	20c.	Location - 0	City or To	wn, State
nor Pages ent of nt: If		1 X Burial 2 Cremation 4 Donation 5 Other Spec		Mi Me	rematory or of the control of the co	1 Gard	dens			4-2008				io
Baltimore, permit. Pages 1 an Department of He Important: If ite	t	21. Signature of Funeral Service L	ense		22	. Name and	Address	of Facility		ll Fun				
	4	23a. Part I. Enter the disease, or co	men	the death						respiratory a			669 rt	Approximate Interval
Physician legical		23a. Part I. Enter the disease, or co failure. List only one cause or	each line.				or dynnig, .	3001 00 00		,				Between Onset and Death
_xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic			ISEASE							\neg	
	Sequentially list conditions, b													
(Disease or injury that initiated Due to (or as a consequence of):														
760, icate be executed physician and the burial - transit		U.												
O, e be es ysiciar burial	Medical	UNPENDED		me of prent	nancy			_			23	3d. Date of	delivery	
FEMALE: 23d. Date of delivery 23d. Date of deliv							Month	Da	y Year					
that the denetable the detached f	Phy			h but not re	esulting in th	e underlying	g cause g	iven in Pa	art I.					e cause of death?
P.O. es that the igned by	þ									No 3	3 Probably 4 ✔ Unknown			
ds, require seen si	The law was an autopsy performed? 1							Were autopsy findings available prior to completion of cause of						
Deformed? Deformed? Deformed Defo								death? 1 ✓ Yes 2 No						
:al Recian: The certificate		25. Was case referred to medical					26.Place	of Death	(Check	only one)				
Vita ysicia this ce direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2	ER/Outpati		OOA	Other ₄		g Home 5		dence 6		Scene
r Attending Physician: The I er death er death irector: After this certificate I n by the funeral director, page		27. Manner of Death 1 ✓ Natural 5 Pendir	28a. Date of Inj (Month, Day,	ury Year)	28b. Time	of Injury	-	ry at Work Yes 2	_	28d. Descri	ibe how ir	njury occurr	ea	
ston trend ceath.	atic	2 Accident Pendii	cation	-i 64 b	- form o	tract factor		-	_	28f Locatio	on (Street	and Numb	er or Rura	al Route Number, City
24a 1 V 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) examiner? 1 Ves 2 No 27. Manner of Death 1 Ves 2 No 28a. Date of Injury (Month, Dey, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of Death (Check only one) examiner? 1 Ves 2 No 28d. Determined								vn, State)						
Die Hospital n 24 hours e Funeral letely filled											d. cause(s)			
≥ 29b. Signature and title of certifier												signed (Month, Day, Year)		
							arch 19,	19, 2008						
	30. Name and a press of person who completed cause of death (Item 23a)													
	1	Pamela E. Southall, MI	O Assistant Med	dical Exa	aminer	111 Penr	Stree	t, Baltin	nore, I	MD 21201	1			
S	tate	31. Date filed (Month ParyYear)	2008 32. Report	ar's Signat	ure	porte	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** March 2068 Robert Cornwell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days | Hours | Min. | Min. | Jan 14, 9. Birthplace (State or Foreign Country) 11nk 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months unk 1 M 2 □ F 59 212-48-9081 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County MD 1 ☐ Yes 2√∑ No Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 3 must be r 6668 Shelly Road 21061 USA Funeral 12. Was Decedent Ever in U.Sunk
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give

1 ☐ Yes 2 ☒ No Specify: Race - American Indian, Black, White, etc. unk or items 11. Marital Status 1 Never Married 2 Married Specify: white by 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk un. (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any injury or other traumatic event, the Magnes." College (1-4or 5+) Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore Washington Medical Center 301 Hospital Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOrner (Specify) in state State Anatomy Board 655 W. Baltimore Street 21. Signatu Rona I d s. Wade Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical o (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**N** No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ac 32. Reg 31. Date filed (Month, Day, State 2008 APR 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 6:32 PM Raymond H. (navez 03 29 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore NIA University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (1) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 □ F 72 Mar 27, 1936 212-32-7199 Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notifled at 1√Yes 2 No MD Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2827 Ashland Avenue 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: \$53–57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tracker operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlos Cortez Lillian Baker ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau Joanna Chavez/Spouse 2827 Ashland Avenue Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Servi 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Part Lanter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solids of the complete Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Vere peripheral valual discose
Due to (or as a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Bilateral lower extremity gargrene use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

24 hours after death. filled in by Hospital completely within 24

> State Registrar

Medical

APR 0 4 2008 DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Tiffano

29a, Certifier

(Check only one)

29b. Signature and title

d manner stated

30. Name and address of person wip completed cause of death (Item 23a) (Type, Print)

Stornard

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

AU4176435521678

South Greene Street, Baltimore, ND 21201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

			Ober 1/10 Black Indelible Ink. Ensure A	•	•					
			State of Maryland / Department of Health and M	vientai Hygie	one inose					
_			Registrar Certificate of Death		NG- 000 10000					
-	Physici	20	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year 3. Time of Death					
	/Medic		Konald G Counselman		31,2008 6:35 PM					
	Examin	100	4a. Facility Name (If not institution, give street and number) Rm 334 4b. City, Town, or Location of Death	1	4c. County of Death					
			Travelodge 200 Walser Dr Frederick		Frederick					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)					
30	Director		513-46-0526 6/ Yrs.	July 12,	1946 Maryland					
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
	aryla •ho	5			1 X Yes 2 □ No					
	8a-f	Director	MD Frederick Frederick							
	or 2	Dir	10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Country?					
	ath v		200 Walser Dr. Room 334 21704		USA					
	tems Tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	or l	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give 1 ☐ Yes 2 💆 No Specify:		Specify:					
21215-0036	within 72 hours after death with the Maryland she. than 'natural', or Items 23e or 28e-f ehow the Mudical Exertines must be notified at	q p	3 ☐ Widowed 4 ☑ Divorced Year or Dates:		White					
7	l within 72 ho iene. r than *natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) (Give kind of work done during most of work)	king 16l	b. Kind of Business/Industry					
12	withir ene. than	m D	Elementary/Secondary (0-12) College (1-4or 5+)							
2			11 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Nam		Route Sales					
E C	ed la be	Be		ne (First, Middle, Mai						
Ë	should be and Mental marked o	٦		lildreth B						
Maryland	120	1.7	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 19c. Mailing Address (Street and Number or Run							
	s 1 and 2 of Health Item 27 I		Mrs. Kim Akonom / Daughter 515 German Drive Hamp		ryland 21074 c. Location - City or Town, State					
Baltimore,			1 Burial 2 Cremation 3 Removal from State Ba Perpins renacrementary							
Ë		i	4 □ Donation 5 □ Other (Specify) @ Loudon Park 4/4/		lltimore, Maryland					
Sal	permit. Departrimportri				k Funeral Home					
14.4	0 □ = 0		Cegen 3620 Wilkens Ave.							
	A		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause or the action actions.	or respiratory arrest,	Interval Between					
	Pnysician		Immediate Cause (Final disease or condition as Unshot wound to he resulting in death)	end	Onset and Death					
	/Medical		resulting in death) Due to (or as a consequence of):	242	, , ,					
	Examiner		Sequentially list conditions.							
	p =	ner	if any, leading to immediate Due to (or as a consequence of):							
ns.	acute and trans	Examiner	Cause (Disease or injury that initiated events c.							
760,	te be executed ysicien and ie burial-transit		resulting in death) Last Due to (or as a consequence of):							
376	ate b hysic the b	lical	d							
68	antificat ing phy e as th	Medi	IF FEMALE:							
Box	attendin for use	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year					
	by the a	Sic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Unknown		Nioniii Bay Foai					
P.0	that the ed by detach	Physician/M		an- Didash-						
Ś	es pe	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	co use contribute to the cause of death?						
orc	w requir been s should	ted	- HIcohol Dependence	1 Tes	2 No 3 Probably 4 Unknown					
ec	has b	ompieted		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
<u>~</u>		S		performed 1 ☐ Yes 2.2	d? death?					
of Vital Record	Physician: The la this certificate has	Be (25. Was case referred to medical axaminer?	th (Check only one)						
2	> @ 0	2		e 6 Other (Specify) MOTE						
		Ë	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?	28d. Describe how	injury occurred					
Sio		Sati	2 Accident investigation Mark 31,2008 Unknown 1 Yes 2 No Shot Self in h							
Division	or Atten after deat Director; in by the	ertification:	3 Suicide 6 ☐ Could not be determined 28e. Place offinjury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) 200 Walser Dr. Km33f						
	CK MD 21704									
	Hosp 4 hou Fune ely fil	edical	29a. Certifier Creatifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the caus	se(s) and manner as stated. and place, and due to the cause(s)					
	To the Hospital or Atte within 24 hours after deg To the Funeral Director cumpletely filled in by the	Med	and manner stated.							
	0 1 × 1 0 0	<	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)					
7		17	Man Kolines MD DME 103/191	1-1)	pril 1, 2008					
	4		30. •• and add of person who complet o cause of death (Item 23a) (Type, Print)	- 1	EAD 2174					
		32	Man Kogrer MDDINE 15 West 1 Street to	calerio	KMD 21701					
			Od Date filed (Marth Day Vers)							
3	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 2008 APR 0 4 2008							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh g878 4-21-08 vt. State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15:24 Рм Patrick 2008 Vito Chucci March 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Prince George's Hospital Gross's If Under 1 Year Junder 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 17 M 2□ F 579 52 9482 Yrs. March 16, Director 1942 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits rithen "naturel", or iteme 23a or 28a-f ehow the Medical Examiner coust be notified at 1 □ Yes 2 □ No Be Completed by Funeral Director Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2218 Shadyside Ave 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 1√∏Yes 2 ☐ No IKYAS, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after c Department of Health and Mental Hygiene. Importent: if Item 27 le marked other then "naturel", or item eny Injury or other traumatic event, the Medical Exercises once. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heating & Air 12 Steam Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph M. Chucci ٩ Antonia Altobello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelina Chucci (Sister) 3905 Clark Street, Capital Heights, MD 20743 20b. Place of Disposition (Name of 20a. Method of Disposition Date CLINCON - City or Town, State Resurrection April 8, 2008 XXBurial 2 Cremation 3 Removal from State Chelteham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) eterans Cemetery 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 Aar1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Atheros claratic Cardiovascular Heart Discing **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is in the cause of the Examiner Due to (or as a consequence of): rsicien and e burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2-No : After this certifical funeral director, I 25. Was case referred to medical Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

I Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Al within 24 hours after c filled in by determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITE 201 31. Date filed (Month, Day, Year) 32. Registrar's Signati State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 28d, perME, g879 5/15/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1416 M Kav Cook Leonora March 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Examiner Dandelion Lang Prince Mar/6010 George's 10.00 If Order 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Dec 30, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√X Months 1939 Washington DC 68 Director 579 54 3255 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2√TNO Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 United States 9217 Dandeloin Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 245 No If Yes, GiveX X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonora Lucille Wallen Kenneth Archie Cook ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 178 Windy Hill Lane, Stuarts Draft, Virginia24477 Garry Lee Cook (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 【**XCremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Lee Crematory March 31, 2008 Clinton, MD 21. Signature of Funeral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 e / r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter shock, or h Immediate Cause (Fina disease or condition **Physician** Counshot Wound to Head resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-tran and resulting in death) Last the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy ned by the atter Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 2 □ No 9□Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed′ 1 Yes 2 ■ Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1.☐ Yes 2☐ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Desidence 6 Other (Specify) ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 544 Certification: Director: After 5 Pending investigation 1 Natural March 14 100 1355 M 1 = 28e. Place of figury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☑ No death. 2 Accident Subject shot self 6 ☐ Could not be 3. Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 9217 Daws extra Lang Lyger Many boro, Md To the Hospital or A within 24 hours after c determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day,

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JULIET M. CAREY MARCH 30 2008 04:30p™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 510 BRIGHTWOOD CLUB DRIVE LUTHERVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 08/09/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 216-46-2634 89 VIRGINIA Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> MD BALTIMORE 1 ☐ Yes 2 No Director LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 BRIGHTWOOD CLUB DRIVE 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 Yes 2 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) VOLUNTEER VOLUNTEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS B. MCADAMS EDNA McLURE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If Item 27 is
any injury or other trau JANE CAREY (DAUGHTER) 44 TENNYSON ST. SOMERVILLE, MA. 02145. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 04/02/08 BALTO. CITY, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111. 21. Signature of Fune al Service License an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration

Due to or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Multiple Sequentially list conditions, it may be a first conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the hurial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensic 1 ☐ Yes 2☐No 3☐ Probably 4☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No Multi-25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1☐ Yes 2☐ No 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 1, 2008 141119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D. McCONNELL M.D. 6301 N. CHARLES ST. BALTO., MD. 21212. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 5 50 P M 28 2008 March /Medical Lawrence Amos Dorman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 **3**M 2 □ F Yrs. Director 213-26-1415 77 July 19, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at a or 28a-f sh 1 ☐ Yes 2 No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a r than "natural", or items 23a the Medical Examiner must I 1103 Abingdon Road 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Totes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: <u>ک</u> 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi salth and Mental Hygiene. U.S. Government Warehouse Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Alma (unk) Dorman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health an Important: If item 27 is any injury or other trau Josephine F. Dorman / Wife 1103 Abingdon Road, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠ Buylal 2 ⊈ cremation Other (Specify) 4 Denation Garrison Forest Cem : Owings Mills, Maryland 4-4-08 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of F 1317 Cokesbury Rd., Abingdon, MD 21009 Part1. En let the sease, or conscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leaf failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a q nsequence of): Examiner robatle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 'olonic as the burial-transit and Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. the detached 9 HUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28

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briman, Lawreha

State Registrar 30. Name and ad

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

depes Chesapsake

Maryland

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Amend Item 23a Pt. I per PCP g883 9/22/08 dk Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Month Day Year Joho Van 00:04 A M /Medical Dril 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore N/A Johns Hopkins Hospital 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 30, ^{Year)} 1 ☐ M 2 💢 F Maryland 220-38-8455 81 Yrs. Dec. Director Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at N/A Md. Baltimore Director 1 _XYes 2 _ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2039 East Lombard Street 21231 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten win Injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. þ Specify. White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clothina 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keller Dora Lenning Gustav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Donovan/ Daughter 2039 East Lombard St. Baltimore, Md. 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-3-08 4 □ Donation 5 □ Other (Specify) Hilltop Service Co. Towson, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician acute respiratory hours /Medical Due to (or as a consequence of) Examiner Spiration 48 hours pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine respiratory infection Vira Due to (or as a count wence of): ronic in lammatory Demyelinating Polneuropathy 10 years Physician/Medical vears IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1∐ Yes 2√2 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, in 24 hours after control the Funeral Director: Af

Baltimore, Maryland 21215-0036

within 2 To the

State

Registrar

31. Date filed (Month, Day, Year)

Medical

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA

APR 04

2008

29b. Signature and fittle of certifier

GOD NORTH WOLFE STREET, BAUTMORE MARYLAND 32. Registrar's Signature

and manner stated,

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

500g

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Paul Vernon Elliott 2008 0123 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore FRANKLIN Square HOSPITAL CENTER Rosedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 12/07/1931 Director 212-28-9994 76 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 Homberg Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 🍇 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Cabinet Maker Cabinetry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 Is marked o any injury or other traumatic eve Paul Xavier Elliott Susan Ann Harding 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Langston (Daughter) 6109 Bellinham Court, Apt. 1132, Balto., Md. 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04/04/2008 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signatu 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final a. Cardiorespiratory

Due to (or as a consequence of): FaiLure **Physician** disease or condition resulting in death) /Medical **Examiner** ELEVATION Myocardial infarction Non-ST soque stally flet out differentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit exacerbation C. O. P. D and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Embolism HISTORY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HyperTension 24a. Was an Pulmonary page 2 autopsy performed? 1☐ Yes 2☑No preu monia POSSIBle STrep certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

land 21215-0036

Maryl

Baltimore,

31. Date filed (Month, Day, Year) State Registrar APR 0 4 2008

HANG

29b. Signature and title of certifier

9000 FRANKLIN Square 32 Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Park

29c. License number

RES0000

DR

Baltimore

29d. Date signed (Month, Day, Year)

4-1-2008

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12050 A-M 2008 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and n Examiner Baltimore University Mary 1049 If Under 1 Year | If Under 24 Hrs. 5. Social Security Nymber 6 Sek 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 27 F Yrs. 01-05-1923 Director 212-74-9033 85 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or intermed other traumatic event than "natural" or intermed other traumatic event than "natural" or intermed other traumatic event than "natural" or intermed than "na 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1421 Redfield Rd 21015 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No g Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franz Fuch ပ Elizabeth Kraus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Stricker (Daughter) 1421 Redfield Rd Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 04-02-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
O-12 NOUVA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (b) as a consequence of) 1-2 hours **Examiner** 08- QUSIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, CENTRECATION To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ COUMadin tor atrial 1 Yes 2 No 3 Probably 4 Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 19⊒Yes 2□ No 2. ■ER/Outpatient 3 DOA P 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural teal March 29 2008 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1300 orto +100Y 1 🗌 Yes 2 Accident 3 ☐ Suicide 6 □ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State)
H21 [Hafield Pd., Bel Air Marylah 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Tecrtifying Physician: To the bask of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d, Date signed (Month, Day, Year) 30. Name and abdress of person who completed cause of death (Item 23a) (Type, Pript)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

(ear)

2.S. Greene

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Year MARCH 29, 11:30 P M EUNICE CHARLOTTE FRY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 Dublin Court Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F Director 192-20-7581 Usual Residence of Decedent July 17, 1926 81 Pennsylvania r 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 102 Dublin Ct. Completed by Funeral 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home marked other • r and 2 should be file f Health and Mental Hy tem 27 is me 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Charles Raymond Long Carrie Irene Hawk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clarence A. Fry / Husband 102 Dublin Court, Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important: If iter
any Injury or oth 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Copr. 4-2-08 4 □ Donation 5 □ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Kuss 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Failure **Physician** Congastin 42012 S /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Certified 29c. License number 29d. Date signed (Month, Day, Year) -2008 12×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPAPHLS LIS MACPHAIL RA, Bel DIN, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 0 4 2008

ALVINO ALVINO

		For State Registrar		Ce	ertificate of		Reg	g. No.	10001
Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	Anthony D. Faraco			1 2. 2		03-29-		0830 A M
Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Dea	ith
		2632 Laurel Valley		//	Abingo	ION If Under 24 Hrs.	8. Date of Birth	Harford	**
Funeral Director		0/3-24-0430	M 2□F	76 Yrs.	Months Days		(Month, Day,)	931 Ne	thplace (State or Foreig ountry) w York
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23e or 28e-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.	L.,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limit
	cto	MD Harford		Abi	.ngdon				
ith th	Olre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
238	œ.	2632 Laurel Valle			2100			USA	
urs after de al', or items Examiner n	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
atur	ted	15. Decedent's Edu		16a. Dec	edent's Usual Occup	pation	10	6b. Kind of Business	s/Industry
within /	mpie	(Specify only highest grade	College (1-4or 5	life.	DO NOT use retire	during most of work d)		Bookkeepe	r
lygie Ther I	ပိ	17. Father's Name (First, Middle, Last)				18 Mother's Name	e (First, Middle, Ma		
ked o	To Be	Angelo Faraco					tkinson	arasir camama,	
mar mar	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mai	ling Address (Street	t and Number or Run	al Route Number,	City or Town, State,	Zip Code)
alth a		Lois Faraco (Wii	fe)	2632	Laurel V	alley Gar	th Abing	don, MD 2	1009
of Hear If Item or othe		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ P	temoval from State	20b. Place of Disp cometery, cr	position (Name of ematory or other pla	ce)	Date 20	0c. Location - City o	r Town, State
men ury		4 □ Donation 5 □ Other (Specify)	-		Crematory			Baltimore	
Depen Import eny in		21. Signature of Funeral Service License	Ruck			^{ess of Facility} Sch V. MacPhai			me of BelA 21014
hysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not ene.		ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death / Week
Physicien: The law requires that the death certificate be executed to the continuous physicien and the continuous been signed by the attending physicien and a director, page 2 should be detached for use as the burial-transit of	by Physician/Medical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	916 54	ro/ke			20 years
requires trial the death certific been signed by the attending pl should be detached for use as t	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	Blivery Day Year
ed by deta	F.	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
pis n		Calon C	ancer				1 🗆 Yes	s 2 □ No 3 □ F	robably 4 Unknow
ete has beel page 2 shou	Completed						24a. Was an autopsy perform	ed? death?	
ertific ector.	Be	25. Was case referred to medical examiner?					h (Check only one	1	
his o	္	1 ☐ Yes 2 ☐ No		nt 2 ☐ ER/Outpatie	SIL SU DON		ome 5 X Residen	nce 6 Other (Sp.	ecify)
- a e	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y Yeer) 28b. Time Injury	Wo	ryat irk?]Yes 2 ∐No	28d. Describe how	v injury occurred	
after death. Director: After	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu City or Town, State)							Rural Route Number,
within 24 hours after death. To the Funeral Director; After this certificate completely filled in by the funeral director, pa.	Medical C	29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one) 12 Medical Examination (Check only one)	sician: To the best of ner: On the basis of and manner sta	of my knowledge, dea examination and/or ited.	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the cau	use(s) and manner a te and place, and du	as stated. le to the cause(s)
vithin To the	Me	29b. Signature and title of certifier	ma		29c. Licens	se number \triangle 53 1 5	6 29	d. Date signed (Mor	
Op.		30. Name and address of person who co	1 -	eath (Item 23a) (Type	e, Print)	Adam	Rd Co	4-1.	ille ms
Sta	te	31. Date filed (Month Day Year)		ar's Signature	9				-1050

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 👇 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 110 AM rance 31 Z008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Spice Whorthwest Hos DWN aITO asons 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace Country) (State or Foreign **Funeral** Months Days 1 ☐ M 2 🔀 F Oct. 1 -24-7940 rainia Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 212 28 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 Widowed 4 □ Divorced Year or Dates "natural", Give kind of work done during most of working life. DO NOT use retired er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry /Secondary (0-12) College (1-4or 5+) ress 1 7 is marked other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) (SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other tr trance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 20a. Method of Disposition Date 12008 1 Burial 2 □ Cremation 3 Pemoval from State Cometer Md. National 4 Donation 5 Dother (Specify) 22. Name and Address of Fability OSEPH L. RUSS 21. Signature of Funeral Service License uneral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE CONGESTIVE ITEMST FAILURE /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9□Unknown Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHALONIC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 1□ Yes 2 2 **1** No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H45931 March 12 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 25 MAIN SILLET Debrah RECSTORSTOWN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 04

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 25,26 per dr., 8878,04,04,08dhb Registratamend #19a PerFH g878 4/21/08 efficient of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 March 12:30 AM Beverly K. Fracalossi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 29, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months 214-22-1172 81 Director 1926 Maryland Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d Inside City Limits show at permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh Important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. MD Baltimore 1 ☐ Yes 2 X No Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd., #2318 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Krug Estella Schoolhaus ပ Roland's Name/Relationship (Type. Print)
Ronald N. Fracalossi/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd., #2318, Parkville, MD 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Du laney cranatory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 03/17/2008 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD mall Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Demention **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 24 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🌋 No ၉ ō in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 24 hours after death. e Funeral Director; After Certification: Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled recrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I 29b. Signature and title of cortific 29c. License number 29d. Date signed (Month, Day, Year) MO March 12th 2005 J3115 0 30. Name and addres pon who completed cause of death (Item 23a) (Type, Print) Walther Prol Parkalle MD 21234 Jeff Landrman 6,00 31. Date filed (Month, Day, Year) APR 0 4 2008 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11 1 20b c per fh 98/8 4-4-08yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year EVELYN **FELDMAN** APRIL 2008 10:00A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Yea 01/28/1906 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 X F Months Days Hours Min. 102 NY 082-01-3435 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∏Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 □Yes 2 No WHITE Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES SAKS FIFTH AVENUE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ISAAC FELDMAN** SOPHIA **POCKER** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED KERN / SISTER 725 MT. WILSON LANE, #206, BALTIMORE, MD 20b. Place of Dispositio 20a. Method of Disposition Date SPRINGFIELD GARDENS 1 ABurial 2 ☐ Cremation 3 A Removal from State MONTEFIORE CEMETARY 04/03/2008 LONG ISLAND, NY 4 □ Dorlation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 art1. Enter the disease, o shock, or heart failure. Lis that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e on each line. Immediate Cause (Final oasto en disease or condition resulting in death) Due to (or as a consequence of): 6. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Diffo (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X** No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M any filed.

Pages 1 and 2 should be nent of Health and Mental

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

2

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-tra attending physician for use the signed by the detach page 2 should has this

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, filled in by the funeral Hospital or Attending after death Director: To the Hospital of within 24 hours a To the Funeral D completely

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Registrar

31. Date filed (Month, Day, Year) State

≱⁄XNo

5 Pending investigation

6 Could not be determined

APR 04

1 🗌 Yes

27. Mann f Death

3 Suicide

29a, Certifier

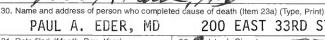
4 Homicide

(Check only one)

29b. Signature and the of ertific

atural

Accident



2008

28a. Date of Injury (Month, Day, Year)

200 EAST 33RD STREET, BALTIMORE, MD 32. egistrar's Sign

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes

2 □ No

28d. Describe how injury occurred

21218

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ZOO Year **Physician** Covunt Amil /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Paltimer Herror Hoopstell 3001 S thundler If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sep 2, 1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F So. Carolina Director 212-22-3702 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No N/A Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21230 ral", or Items 23a Examiner must b 2609 South Paca Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Paper Box Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Grant is marked Samuel Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any Injury or other trauonce. 8314 Liberty Road Baltimore, Maryland 21244 Clarence Grant Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 04/07/08 Western Cemetery 4 Donation 5 D Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service License f a 11. Enter the disease, or complications that cause it shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary mins /Medical Due to (or as a consequence of): **Examiner** 1 wenter er venous Seque: titally hat conclors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforn 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 0 4 2008

DHMH 17 Rev 1/2001

and manner stated

E.FOT 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

901

29c. License number

D39660

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April 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 29°, 2008° 9:45 A M Rita L. Gemmill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Holly Hill Nursing Home Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6/5/1916 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗙 F Maryland 705-10-9253 91 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Ruxton Road apt A-1 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2K No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment. College (1-4or 5+) Elementary/Secondary (0-12) Personal Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lenhart Beatrice L. (Not Known) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gemmill / Husband 1600 Ruxton Road apt A-1 Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4/2/2008 4 □ Donation 5 □ Other (Specify) Hilltop Serv.Corp. Towson, Maryland 21. Signature of Superal Service Licensee 22. Name and Address of Facility Towson, Maryland 21204 Tell Ruck Towson Funeral Home, Inc. 1050 York Road 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): D years /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 5 WS Due to (or as a consequence of): Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No 1∐ Yes Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

Baltimore,

68760.

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted Houkimb 7402 York Road #301,

32. Registrar's Signature

Towson,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHARLES GOODWIN APRIL 2008 11:35p^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4204 UNDERWOOD RD BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 12/21/1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1**X**M 2□ F MARYLAND 220-22-3321 Yrs 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4204 UNDERWOOD RD 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 + College (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. LAWRENCE GOODWIN FRANCES KENNY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE OBER GOODWIN(WIFE) 4204 UNDERWOOD RD. BALTO., MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State DRUID RIDGE 04/07/2008 PIKESVILLE, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility HENRY W. JENR JENKINS & SONS CO. YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCREATIC disease or condition resulting in death) ANCER MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ※ No 24a. Was an autopsy 1□ Yes 2 X No 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

other traumatic event,

al Hygiene.

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of Health Item 27 i

Department of H Important: If Ite any injury or of once.

Director

Funeral

Completed by

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

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Division or Vital Records,

death certificate be

Examine Physician/Medical þ Completed

Certification:

Medical

burial-transi and attending physician as the detached page 2 certificate Be funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Yes 2 No

27. Manner of Death

1 X Natural

2 Accident

3∏ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

26. Place of Death (Check only one,

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier M

5 Pending investigation

6 Could not be

29c. License number DOO 53364 29d. Date signed (Month, Day, Year) 2008 APRIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury

and manner stated.

(Month, Day Year)

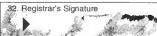
10755 FALLS RD LUTHERVILLE, MD. 21093. WILLIAM QUEALE M.D.

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year)



After

death.

within 24 hours after death To the Funeral Director:

To the Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Comus Duster Holmes	State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Ce	ertificate of	Death		R	teg. No.	10 1001
Physic		1. Decedent's Name (First, Middle,L	ast)				2. Date of Dea	ith	3. Time of Death
Medical Exam	iner	Comes Descent Relation				Month March 26	Day Year , 2008	2311 hrs	
		4a. Facility Name (if not institution, g	give street and number)	4	b. City, Town, o	or Location of	Death	4c. County of Dea	th
		Malcolm Grow Medical C	Center		Camp Spr	ings		Prince Georg	j e 's
Funeral		Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye	_		rth(MM/DD/YYYY) 9. B	1 mm
Director	1	217-19-0004	x м 2 F 25	Yrs.	Months Da	ys Hours	Min. 11–18	-82 Fore	ountry) Wash
		Usual Residence of Decedent					111 11		20
япу		10a. State 10b. County		y, Town or Location	on				10d. Inside City Limits
nd show	×	MD Prince	e George's Su	itland					1 Yes 2 X No
Maryland 28a-f show datonce.	ect	10e. Street and Number			10f. Zip Code			l0g. Citizen of What Co	untry?
the N a or 2	Director	3813 Swan Road			20746			USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once	<u>a</u>	11. Marital Status	12. Was Decedent Ever in I		Decedent of H	lispanic Drigin	? (Specify Yes or No		erican Indian, Black,
death r iter	Funeral	1 X Never Married 2 Marrie	ed Armed Forces?	If Ye	s, specify Cuba	an, Mexican, F	Puerto Rican, etc.)	White, etc.	
after al", o	by F	3 Widowed 4 Divorc	ed If Yes, Give Year	1	Yes 2 X N	o specify:		Specify: B1	ack
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, th Medi -1 Examinger		15. Decedent's Education (Specify	only highest grade completed)				nd of work done	16b. Kind of Business	s/Industry
6 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	- auring mo	st of working lif	e. DO NOT us	se retired)		
5-0036 led within 72 Hygiene. other than the Medical	ם	11		N/A				N/A	
5-C		17. Father's Name (First, Middle, La	st)			18.Mother's	Name (First, Middle,	Maiden Surname)	
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, th. Medi-	Be	Milton Markeit						verly Seato	
D 2 should and M is m	٤	19a. Informant's Name/Relationship		10				mber, City or Town, Sta	
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. The mary or in marked other than "matural", or items 23a or 28a-f she traumatic event, the Mediral Examiner must be notified at once		Milton Holmes -						lphia, PA	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with: Department of Realth and Mental Hygiene. Department of Realth and Act of the I in I in the I in I in I in I in I in I in I in I i		20a. Method of Disposition 1 X Burial 2 Cremation 3		Place of Disposi- crematory or oth olmes Fa		emetery,	Date	20c. Location - City of	or Town, State
more Pages 1 nent of H ant: If it		4 Donaion 5 Other Speci	ify:	olmes Fa emetery	mily		4-3-08	Middlesex	County
Balti Permit. Departm Imports injury o		21. Ignatur of Funeral Service Lie	tinsee	22. Na	ame and Addre	ss of Facility	R. K. Red	dmond Funer	al Home
ω ₽₽ ≡ iii		& Lennis (F)	Hum					acklefords,	
Physician		23a. Part I. Enter the disease, or cor failure. List only one cause on		h. Do not enter th	e mode of dying	g, such as car	diac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
'Medical xaminer			a. Multiple Injuries						Death
Xammer		or condition resulting in death)	Due to (or as a consequence	of):					
	L	Sequentially list conditions,	b						
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):					
31/	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
cuted and transi			d						
3760, Efficate be executed g physician and si the burial - transit	/Medical	UNPENDED	AMENDED						
5 t 4 6	Me	IF FEMALE:	23c. If yes, outcome of pre					23d. Date of delive	ery
Sox 687 leath certific e attending for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		al death 3	Ectopic p	regnancy	Month	Day Year
Box 68 e death certil the attending	Physiciar	1 Yes 2 No 9 Unknow	4 Pregnant at time of d	leath 5 Oth	er (Specify)			1	3
the de	Phy	Part II. Other significant conditions	9 Unknown	roculting in the un	dod in a source	sives in Dest	1 220 Did t	obacco use contribute t	a the series of death?
ires that the signed by	و	Tare in Octoor Significant Conditions	contributing to death but not	resulting in the di	idenying cause	givenin Fait			obably 4 Unknown
lS, l	ed								,
of Vital Records, g Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed						24a, Was autoj	osy prior to	autopsy findings available completion of cause of
Rec The 1 cate h	ē							ormed? death?	
ital Rec ician: The s certificate rector, page	Be C	25. Was case referred to medical			26.Plac	e of Death (C	heck only one)		
Vit;	10 8	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other 1	Nursing Home 5	Residence 6 Oth	er:
r of ing Pl After uneral		27. Manner of Death	28a. Date of Injury	28b. Time of In	ury 28c. Inj	ury at Work?		how injury occurred	
Division tal or Attendir as after death. al Director: A led in by the fu	읉	Natural 5 Pending Accident Investiga		2216 hrs	1_	Yes 2 🗸 N	briver auto	auto collision	
ivision or Attendafter death Director:	ij	2 ✓ Accident Investiga 3 Suicide 6 Could no	28e Place of Injury - At h	nome, farm, street	, factory, office	building, etc.			Rural Route Number, City
Division of Vital Records, P.O. Box 68 optial or Attending Physician: The law requires that the death certimeral After death. Inneral Director: After this certificate has been signed by the attendin. It filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide determin		ad / Highway			or Town, S Westbound S	State) Suitland Parkway , , N	/ID
= 4 E 0		29a. Certifier (Check only 1 Certifying Physics)	cian: To the best of my knowled	dge, death occurre	ed at the time, o	date and place	e, and due to the caus	se(s) and manner as sta	ated.
To the J within 2 To the J complet	edical		er: On the basis of examination and manner stated.						
F > F 8	₹	29b. Signature and title of certifier	t.		29c. Licen	se number		29d. Date signed (M	onth, Day,Year)
	- 1	Down my Ding	ed, No.		O.C	M.E.		March 28, 2008	
3	ŀ	30. Name and address of person who		n 23a)	<u> </u>				
V			Assistant Medical Exa	•	Penn Stree	t, Baltimor	e, MD 21201		
St	ate	31. Date filed (Month, Day Year)	32 Registrar's Signal	tue A	2 2				
Regis	rar	31. Date filed (Month, Day, Year) 20	NO Chalus N	tire Spans					

HARROW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			4 80.	partment of Health and Nertificate of Death	lental Hygie	2000	10875
Mi.	Dhysia		Decedent's Name (First, Middle, Last)		Date of Death Month	Day	3. Time of Death
7	Physic /Medi		Sylvia Kathleen Harris		April 1,	Day Year 2008	11:55 A.M
	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1 == 100 114
"			2942 Hampstead-Mexico Road	Hampstead		Carroll	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2XXF 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		
			Usual Residence of Decedent		Aug. 25,	1926 Mary	yland
	yland how at		10a. State 10b. County 10c. City, Town or	ocation		1	0d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show inth, the Medical Examinar must be notified at	Funeral Director	Maryland Carroll Hampste	ad			1XX es 2 No
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g. I In	Citizen of What Cour	ntry?
	s 23a	la	2942 Hampstead-Mexico Road	21.074	of	America	
	er de item ner n	n.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	ırs aft Il", or xami	by F	1 □ Never Married 2 □ Married 1 □ Yes 2/€No If Yes, Give '3/€Nidowed 4 □ Divorced Year or Dates:	1 ☐ Yes XX No Specify:		Specify: Whi	ite
9	"natural", "natural",	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/Inc	dustry
215	thin 7 e. an "n Medi	ple	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ing		-
21	filed withir Hygiene. ther than	Completed	12th	Homemaker		Own Home	
pu	be filed within 72 hortal Hygiene, id other than "natu event, the Medical	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Surname)	
yla	ould be I I Mental I narked of	၉	William H. Shaffer, Sr.		Grace Hanı	•	
Maryland 21215-0036	d 2 should be filed th and Mental Hygi ? Is marked other traumatic event, ti			ling Address (Street and Number or Run			
	1 an Heal em 2	1	20a. Method of Disposition 20b. Place of Dis	Hampstead-Mexico		Ostead, Ma Location - City or To	
nor	0 - - =		MXBurial 2 ☐ Cremation 3 ☐ Removal from State Snydersb	ematory or other place) Apri. urg Church Apri.		•	,
Baltimore,	permit. Pag Department Important: I any injury o once.	1	Cemetery Cemetery	2008	Sny	dersburg,	Maryland
B	permit. Departr Importa any inji		() An Olymath. B	22, Name and Address of Facility Ckhardt Funeral Ch 296 Charmil Drive,	apel, P.A.	Marvila	2011 C 5a
Н			23 Part 1 Enter the disease, or complications that caused the death. Do not end fock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	er, naryra	
	Physician		Immediate Cause (Final disease or condition	Da Marila	1	. IV.	Approximate Interval Between Onset and Death
7	/Medical		resulting in death) a. Due to (or as a consequence of):	man here	VII		MINUES
Н	Examiner	.	Sequentially list conditions b. Council Q	atery Disea	se)	5 years
7	ed sit	Examiner	Sequentially list conditions, it any, teading to immediate cause. Enter Underlying Cause (Disease or injury	J			0
V	be executed ician and burial-transit	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	sate be executed oblysician and the burial-transit	lical E					
9	requires that the death certificate een signed by the attending physi rould be detached for use as the	edic	0.				
Вох	ending use	₹	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delive	ery
	e deat	sicia	1 Yes 2 No	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.0	at the	Physician/Med	9 DONKHOWN				
	w requires that the death certific. been signed by the attending pl should be detached for use as t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
OIC	requi	ted	79/2 11 1011		1 Tes	2 No 3 Prob	ably 4 □Unknown
3ec	e law has b e 2 sh	Completed by	alzhermens Disease		24a. Was an autopsy	prior to cor	psy findings available inpletion of cause of
a	n: The icate h				performed 1 Yes 2 ☑	? death? No 1 ☐ Yes	2 ½ No
ΖÏ	Physician: this certific raf director,	00	25. Was case referred to medical examiner? 1 □ Yes 2 N No Hospital: 1 □ Inpatient 2 □ EB/Outpatie	O45	(Check only one)		
Division or Vital Records,	Phy:	은	27. Manner of Death 28a. Date of Injury 28b. Time	All Nursing Ho	me 5 Residence 28d. Describe how in	6 □Other (Specify)
on	Attending r death. ector: After by the funer	ţi	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Edd. Doddino now a	july occurred	
N S	Atter	ifica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s	treet, factory, office	28f. Location (Street	and Number or Rura	l Route Number,
	tal or s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St.	ate)	
	Hour Hour Uner	cal	29a. Certifier (Check only analy) 1 **Certifying Physician: To the best of my knowledge, determined to the basis of examination and/or analysis.	th occurred at the time, date and place,	and due to the cause	e(s) and manner as st	ated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical	and manner stated.				
	Nit Col		29b. Signature and title of certifie	29c. License number D00361/2		Date signed (Month, I	
		_	MODELLA IND		07	1-03-0	0
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		///- 0	
	Sta	te_	D. Heiander Rucha MD 4231 NOTH 31. Date filed (Month, Day, Year) 32 Registrar's Signature	words I all Han	ipsuad ,	40 210	17
	Registr		APR 0 4 2008 Sie A	woods Trail Han			

DHMH 17 Rev 1/2001

08-02480		Please Type or Print in Black Indelible Ink. Er	nsure All Copies	s Are Legi	ible.	
Daniel Lewis Han		State of Maryland / Department of Healt For State Certificate of Death			20	08 108
Physicia	R	egistrar Decedent's Name (First, Middle,Last)		2. Date of Death	. No. Day Year	3. Time of Death
M Examin		Daniel Lewis Harrison		Month March 29, 2	2008	1450 hrs
•		a. Facility Name (if not institution, give street and number) 4b. City, T	Town, or Location of Death		4c. County of Deat Harford	٦
		557 Chestnut Hill Road Fores Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undo		8 Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or
Funeral Director		Month		1	Forei	gn ountry)
Director	ŀ	213-92-7058 1 x M 2 F 45 Yrs.		11/08/	1962	MD
any	- 1-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ind show	ا ج	MD Baltimore Parkville				1 Yes 2 X No
Maryla 28a-f	Director	0e. Street and Number 10f. Zip) Code	10	g. Citizen of What Cou	intry?
11215-0036 Ide filed within 72 hours after death with the Maryland Aental Hygiene. narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.			234	asifu Vac as No.	USA	rican Indian, Black,
ems 2	Funeral	1. Marital Status 1. Never Married 2. X Married Armed Forces? 1. Never Married 2. X Married Forces? 1. Never Married 2. X Married Forces? 1. Never Married 2. X Married Forces?	ent of Hispanic Origin? (Spe ify Cuban, Mexican, Puerto F	ecity res or No- Rican, etc.)	White, etc.	ncan indian, black,
or it		1 x Yes 2 No	X No specify:		Specify: T	Thite
urs aft	ğ	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual	Occupation (Give kind of w	ork done	16b. Kind of Business	
72 hou	eţe	Elementary/Secondary (0-12) College (1-4 or 5+)	orking life. DO NOT use retire	ea)		
5-0036 iled within 77 Hygiene 1 other than	Completed	12 Roofer	18. Mother's Name	(Circh Middle N	Construct	ion
filed v Hygir d other		17. Father's Name (First, Middle, Last)				
2121 buld be fi Mental I marked	To Be	Lewis N. Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Marlene s (Street and Number or R	Harr Rural Route Num	ber, City or Town, Sta	te, Zip Code)
MD 2 d 2 shou lth and h n 27 is n	Ť				e, MD e, ND , 212	34
e, N l and 3 Health item 3		20a. Method of Disposition 20b. Place of Disposition (Na	ame of cemetery,	Date	20c. Location - City	or Town, State
nor ages ent of nt: If	ı,	1 X Bunal 2 Cremation 3 Removal from State A Deposition 5 Other Specific Parkwood Ceme	etery 04/	/04/2008	Parkvill	MD_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical I	1	21. nature of Funeral Service Licensee 22. Name and	d Address of Facility Dud	la-Ruck	Funeral Ho	ome of
E P P E		V)9 ((all 17922)	Wise Ave. Du	indalk,	MD 21222 D	oundalk, Inc. Approximate Interval
'nysician Medical	7	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	or dying, such as cardiac or	r respiratory arre	sor, orreard, or record	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Narcotic Intoxication Due to (or as a consequence of):				
		Sequentially list conditions, b.				
	ner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
	Examine	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
nd ared of the	_	d.				
760, ficate be execute g physician and	sician/Medical	X UNPENDED X AMENDED 19b,23a,27,28a-f per M	E g878 4/23/08 a	amh.		
Box 68760, the death certificate but the attending physic ed for use as the but ed to the but	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3 Ectopic pregna	ancv	23d. Date of deliver Month	ery Day Year
certifications	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Sp		arioy		,
Box death he atte d for u	ysi	1 Yes 2 No 9 Unknown g Unknown				
o. or nat the od by t	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.			to the cause of death?
S, P nires th	ed by			24a. Was		autopsy findings available
ords w request shoul	plet			auto		to completion of cause of
Records, P.O. Box 68760, The law requires that the death certificate be care has been signed by the attending physicil page 2 should be detached for use as the buril.	Completed			1 🗸 Yes		
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rate death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be C	25. Was case referred to medical examiner? Hospital: Innation 2 ER/Outpatient 3	26.Place of Death (Check		Residence 6 🗸 0	thor: Scene
n of Vital ing Physician: After this certif funeral director,	701	1 ✓ Yes 2 No Troophen 1 Inpatient 2 ER/Outpatient 3	DOA Nursii 28c. Injury at Work?	ng Home 5	how injury occurred	mer, ocene
nol	ion:	(Month, Day, Year)	1 Yes 2 X No	Unk		
IVISIOR or Attend after death Director:	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factor	ory, office building, etc.	28f. Location (Rural Route Number, City
Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) House		or Town, 557 Ches	state) stnut Hill Rd	., Forest Hill,
Hospi 24 hou sely fil	S S	29a. Certifier Continue Rhygician: To the best of my knowledge death occurred at t	the time, date and place, an	d due to the cau	se(s) and manner as	stated.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred	at the time, date	and place, and due t	the cause(s)
F » F »	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (March 30, 200	
		Mayora Melhall	O.C.M.E.		IVIA1011 30, 200	
A		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD	21201		
\mathcal{Q}	1	Margania Notell MD. Assistant Medical Examinor 1111 cm	,			

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar APR 0 4 2008

🙉. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** Ρ. Heathcote 2008 Catherine 4:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner N/A 1454 West 36th Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Hours 1 □ M 2 XF Months Days oct 22 215-14-9491 Yrs Director 85 1922 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits "natural", or items 23a or 28a-f show edical Exaπiner must be notified at 1 XYes 2 □ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1454 West 36th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2**X** No 2 3 Widowed 4 □ Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H fitem 27 is marked oth Be Clarence S1enbaker Marv Jane Weaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Inners - Son 2420 Forest Hill Road, Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/2/2008 4 Donation 5 Dother (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. Williams 22, Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (ur as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform this certificate 2 No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28h. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certific 29c. License number 29d. Date/signer (Month, Day, Year)

2

State Registrar Beong

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

APR 0 4 2008

32 Registrar's Signatur

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 04

32. Registrar's Signature

2008

Amend Item 21 per dvr., g878,04/04/08dbbcate of Death

State of Maryland / Department of Health and Mental Hygiene dvr., g878,04/04/08dbbcate of Death

Reg. No. Reg. No. 2. Date of Death 3. Time of Death Year **Physician** dus /Medical Neme (If not institution, give stree 4b. City, Town, or Location of Death 4a. Pacility Examiner If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X**M 2□ F 08/28/1823 84 Oregon Director 5**43-18-43**29 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow rthan "neturel", or items 23a or 28a-f ahov the Medical Examiner must be notified at MD Director Prince George's Laurel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8509 Portsmouth Drive 20708 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electronics 12 7 is marked other traumatic evant, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi end Mental I Be t and 2 should by Health end Ments lem 27 is marked Carl Alexander Illig Rosalie Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Illig - son 8414 Sandalwood Court, Jessup, MD 20794 other Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **=** 5 **Department** Important: any injury o 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S. Wade, Director per DVR State Anatomy Board, 655 W. Baltimore St. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** CarebraL /Medical Immediate Cause (Final disease or condition resulting in death) Examiner cerebrovascular D Hease Examiner law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physiclan/Medical Due to (or as a consequence of) attending pl ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown pertension þ Deficieny Anemin should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? been ULCER DISESSE certificate has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide ò 24 hours e Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as stated. ca 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi To the I within 2 and manner stated. 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print).

A Warren 321 Numb Ceorge S 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2008 Registrar

DHMH 16 Rev 6/95

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

30. Name and address of person who/completed cause of death (Item 23a) (Type, Print)

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32. Registar's Signature

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OSLER DRIVE TOWSON MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** March 27, 2008 2:08 P M Danielson Jensen Sandra /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charles Port Tabacco 7635 Carley Drive If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 9. Birthplace (State or Foreign Country) Washington DC 8. Date of Birth (Month, Day, Year) Nov 30, 1939 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 🗆 M 219 34 9963 68 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show the Medical Examiner toust be notified at 1 ☐ Yes 2 ☐ No Director Maryland Charles Port Tabacco 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20677 7635 Carley Drive by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes \$ TNO 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ¥ ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' ury or other traumatic evant, Ite Ma Elementary/Secondary (0-12) College (1-4 or 5+) Entertainment Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Robey William A. Danielson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3612 Denison Street, Frederick, MD 21704 Judith Milligan (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Cedar Hill Cemetery March 31, 2008 Suitland, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Prvice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 164 Alexandria Ferry Road, Clinton, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediete Cause (Final disease or condition resulting in death) 7-101 Physician /Medical Due to (or as a conse duence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of) Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 Probably Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No certificate 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. De cribe how injury occurred 27. Manner of Deuth Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Fo the Hospital 1 Kertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 32. Signatur

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jacqueline M. Jones 4 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Kosedale Franklin Square Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 01/02/1946 5. Social Security Number In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🔀 F Maryland 62 218-44-3517 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4513 Fieldgreen Road 21236 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens important: If Item 27 is marked other this any injury or other traumatic event, the one. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Mary Schirmer Henry Berger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jones, Son 4513 Fieldgreen Road, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. 04/03/2008 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Maxandria & Blan 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner rforated Small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1√Natural 5 ☐ Pending investigation Within 24 hours are:
To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29b. Signature and title of perting 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muchard 9000 Franklin Square Drive, Baltimore, M 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

APR 0 4 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Depar State Registrar Certif		and Mental Hygie	•	0884
			Decedent's Name (First, Middle, Last)		2. Date of Death	3.1	Time of Death
	Physici		Margaret Jacobs		Month 03 3	Day Year	5:30 A M
	/Medic Examin	_		4b. City, Town, or Location o		4c. County of Death	
			Ridgeway Manor Nursing Home	Catonsv	ville	Baltimor	~e
	Funeral		1 N OME	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, Y	9. Birthplace (Country)	State or Foreign
	Director		421-18-7662 88 Yrs.	,	11-10-1	919 Alabama	à
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation		10d. In	side City Limits
	Maryl f sho	ō	Md. Baltimore	F	Baltimore	11	□Yes 2 No
	28a-	rec	10e. Street and Number	10f. Zip Code		: Citizen of What Country?	
	3a ol		6205 Falls Road	2120	09	USA	
	deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Armed Forces?	as Decedent of Hispanic Orig Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	14. Race - American Inc Black, White, etc.	dian,
9	or Its	/Fu	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:	, 1 0010 (110211, 010.)	Consider	
93	ural',	d by	3 ★ Widowed 4 Divorced Year or Dates:			WILL	
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12	withir ene. than	mc	Elementary/Secondary (0-12) College (1-4or 5+)	nemaker		Own Home	
9	filed Hygi othar ant, I	ပိ	17. Father's Name (First, Middle, Last)		n's Name (First, Middle, Ma		
<u>a</u>	ld be ental kad c	To Be	Yearby Reed		Mary Co	oley	
Maryland 21215-0036	shou a mar umat	-	3	Address (Street and Number			9)
Σ	alth a alth a 127 is		Tammy Coccagna/Grand Daughter 6205 F	alls Road Ba	altimore, Mar	yland 21209	
ore	es 1 and of He fitam		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposit cometery, crema	tion (Name of atory or other place)	Date 20	c. Location - City or Town, S	State
Ĕ	Pag ment ant: 1 ury o		*4 Donation 5 Other (Specify) Hilltop Se	ervice Corp. 🗸	4/2/08 To	wson, Marylar	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Eventine must be notified at once.			Name and Address of Facility 150 York Road			e, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				roximate
				and the second s		Onse	val Between et and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	u voneal	و	40	ass
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Box (certiticat nding phy use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
ă	The law requires that the death the has been signed by the atten vage 2 should be detached for u	Iclai	in the past 12 months? 4 Pregnant at time of death 5 0	ctopic pregnancy Other (specify)		Month Day	Year
P.O.	t the by the ache	hys	9 Unknown				
	ss tha	by P	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did toba	cco use contribute to the cau	use of death?
ğ	v require been sig should b	ed	Hyperteusion		1 Tes	2 No 3 Probably	4 AUTKnown
သိ	taw reas be	plet	Dialetes		24a. Was an autopsy	24b. Were autopsy fin prior to completi	ndings available
Œ	The ate ha	Completed	Deneut'a		performe	death?	
/ita	sician: The tav certilicate has rector, page 2	Be (25. Was case referred to medical examiner?		of Death (Check only one)		
<u></u>	hysic his co	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		rsing Home 5 Resident		
<u>_</u>	ing P	on:	27. Manner of Death 1 Patural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
<u>.s</u>	ttand death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be aga Pleas of Injury. At home form gives	M 1 Tes 2 T		et and Number or Rural Rou	to Number
Division of Vital Records,	or All atter of Dirac	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	it, factory, office	City or Town,		te ivaniber,
	spital ours naral fillad	CO	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and	d place, and due to the cau	se(s) and manner as stated.	
	To the Hospital or Attanding Physician: The law within 24 hours atter deadsh. To the Funeral Director: After this certilicate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or inve- one)	stigation, in my opinion, deat	th occurred at the time, date	and place, and due to the o	cause(s)
	To th Within To th somp	Me	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day,	
		Ni I	Mariae Que ans	D19667	0	3-31-200	8
_	16		30 Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)	#== 0 0: 0	03-31-200 writer, blosyland	1 72.00 1
	7		Mechael Showard D 7310 Kitch	ie Hichway	"SON Glen K	when Haryland	20 2106/
	Sta	4.1	31. Date filed (Month, Day, Year) 32. Registrar's Signature	The state of the s			
DL	Registr MH 17 Rev 1/20		APR 0 4 2008 Flower & Apr	all -			
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State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ^{Day} 2008 Roger W. Klein March 8, 12:50 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Vermont Avenue Earleville Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 215-58-1170 Director 56 Mar 12, 1951 Pennsylvania Usual Residence of Decedent ibe filed within 72 hours enter-ntal Hygiene. sed other than "natural", or items 23a or 28e-f ahow ic avant, it a Mudical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Cecil Earleville 1 ☐ Yes 27 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Vermont Avenue 21919 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ð Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental H itam 27 ta marked otl Frederick Klein Eleanor MacComb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy W. Klein/spouse 11 Vermont Avenue Earleville, MD 21919 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages nent of P ant: if its 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if any injury or once. 4 ☑ Donation 5 Other (Specify) 21. Signature of Funeral Servi State Anatomy Board 655 W. Baltimore Street mn baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, physicien Physician/Medical attending I 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death signed by the a Id be deteched for 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been si 3 Probably 4 Unknown Completed 1 Yes 2 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate performed? 1 Yes 2 No 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 20 No ဥ 1 Tes 3□ DOA this To the nosperation after death.

To the Funeral Director: After this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: Division 1 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of certifier 29d. Date signed (Month Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) MI 150m We oria OV 31. Date filed (Month, Day, Year) 32. Registrar's Signature ganle State APR 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Dav Year Knauer Kore 03 2008 4b. City, Town, or Location of Death 4c. County of Death 1902MA Bel Air Harford 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Days 1 □ M 2 ☑ F Months Hours Min. Country 01,1949 Mary 10c. City, Town or Location 10b. County Bel Air 10f. Zip Code 10g. Citizen of What Country? 21015 USA

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2047 PM trance sca /Medical 4a. Facility Name (If not institution, give street and number) Examine Chesaneake 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 218-48-2668 USA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature!" 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford 10e. Street and Number 2004 Ruffs Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2√2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Marie Brusio Angelo (unk) Stefanoni 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Ruffs Mill Road, Bel Air, Maryland 21009 Joseph S. Knauer Jr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Ignatius Cath. Chr. 4-4-08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdo

23a. Part1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final **Physician** Myocardia archov disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner ardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the training resulting in death) Last Due to (or as a consequence of) 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Récords, Completed by ner ten Hor 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed' certificate 1∐ Yes 2 1 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Zadorian. D0066366 Komi

State

Registrar

30. Name and

nywho completed cause of death (Item 23a) (Type, Print)

orian

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Dedent's Name (First, Middle, Last) 2. Date of Death March Physician /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bunner 5altimore er 1 Year | If Under 24 Hrs. s Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months 213-90-6713 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 LOAO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DONOT use retired) Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be ၉ 194. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3906 Donne 20b. Place of Disposition (Name of centretery, crematory of other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEPATOCELLULAR CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit P.O. Box 68760,€ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 12 Natural in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 T Accident fter death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier march 31, 2008 current sears MO D16619 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) DRIVE, NOTINGHAM, MD 21236 SOUARE C. VERGARA-SOARES 9940 FRANKLIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State LOBALE.

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Registrar

APR 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		101	Department of Health and I Certificate of Death		ne No. 2000 1000
Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth Ann Lane		2. Date of Death Month April 1.	Day Year 3. Time of Death 2008 7:35 PM
/Medica Examine		4a. Facility Name (If not institution, give street and number) 6606 Blackhead Rd.	4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		8. Date of Birth (Month, Day, Young 28, 1	9. Birthplace (State or Foreign Country)
f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Baltimore Mid			10d. Inside City Limits 1 □ Yes 2∕XNo
with the Na or 28a-1	Direc	10e. Street and Number 6606 Blackhead Rd.	Idle River 10f. Zip Code 21220		Citizen of What Country?
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ☑ No Specify:	pecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 nd 2 should be filed within 72 hours att alth and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Examirations.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Homemaker	king	b. Kind of Business/Industry Own Home
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Italia Magnee.	စ္က	17. Father's Name (First, Middle, Last) Joseph Nevins		ne (First, Middle, Mai	
Mary and 2 sho eath and 1 27 is ma ner trauma		Richard Lane (Husband)	Mailing Address (Street and Number or Ru 5606 Blackhead Rd. Ba		•
Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any Injury or other page.			Disposition (Name of y, crematory or other place) Hill Mem. Gardens 4/4		c. Location - City or Town, State
Balt permit Depart Import any Inj once.	,	21. Signature of Funeral Septice Licensee	22. Name and Address of Facility Bruzdzinski Funera 1407 Old Fastern A	Avenue Ess	ex. Maryland 21221
Physician /Medical Examiner	ner	23a. Part I Inter the disease, or complications that caused the death. Do not show he art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Expert Indexiving.	Cart desease		Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cons	of):		
P.O. Box nat the death cert d by the attending etached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that sheen signed to should be deta	2	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 (2) Probably
ral Reco	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ∑	
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Certification: 10 Be	27. Manner of Death 1 🛣 Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day, Year)	Other	th (Check only one) ome 5 ☑ Residence 28d. Describe how	te 6 ☐ Other (Specify) injury occurred
Divis		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		City or Town, S	
o the Hosp Ithin 24 ho the Fune Impletely fi	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge 2 ★ Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
		Manu Karalustic us	D21022		4-2.08
State		M. KWALSUHK MD. 7602 B50 31. Date filed (Month, Day, Year). 32. Registrar's Signature.	AIR Nel SALTO-M	1).243	6
Registra	r	31. Date flied (Month, Day, Xear) APK U 4 2008 32. Registrar's Signature	de		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **∑**Day APCI JOHN FREDERICK LANGENFELDER, SR. 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square 5. Social Security Number 6. S Rosedale Hospital center 8. Date of Birth (Month, Day, Year) Mar. 4, 1926 7. Age (In yrs. last birthday) Months Days Hours Min 1**X** M 2□ F Mar. Maryland 82 217~26~3855 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☑ No Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 7413 Brightside Avenue 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) N/A Equipment Operator BG &E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Langenfelder Frieda Kohls 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Langenfelder (Wife) 7413 Brightside Avenue Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X1X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Zion Church Cemetery 4~5~2008 Baltimore, Md. ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee MARCO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroselerotic Cardiovascylar disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for its a consequence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2√ER/Outpatient 3 DOA 1 Inpatient

Physician /Medical Examiner the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

t be notified at

Is marked other than "natural", or items 23a raumatic event, the Medical Examiner must be

Baltimore, Maryland 21215-0036

Box 68760,

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or Vital Records,

Hospital or Attending

angenfelder

1 and 2 should be filed withi Health and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.

Director

Funeral

Completed by

Be

nding physician and use as the burial-transit ed by the detached Certification: To

Physician/Medical Completed by Be

27. Manner of Death 1 √ Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Examiner

this After this funeral of death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

Medical

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

and manner stated.

29c. License number D 0061662

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

04/02/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin Square Drive, Baltimore MD, 21837 Dr. Jonathan 31. Date filed (Month, Day, Year)

APR 0 4 2008

5 Pending investigation

6 ☐ Could not be

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:00 AM april 2008 Leonard Isaac Lutwack 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Keswick 8. Date of Birth Apr. 18, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Year) 1917 Days Hours 1 ☑ M 2 ☐ F 90 045-12-5714 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 104 Kenilworth Park Drive #3B 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professor University of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morris Lutwack Augusta Zerwitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Kenilworth Park Drive #3B; Towson, MD 21204 wife Ruth T. Lutwack 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. Towson, MD 1050 York Road 4/3/2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rkrusseleritie cardinaseular Years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) 1 Yes Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2010 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medicai Examiner The law requires that the death certificate be executed

Department of I Important: If its any Injury or o

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show the notified at

ns 23a o

Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. wit: If item 27 is marked other than "natural", or items 23. Iny or other traumatic event, the Mediezal Examiner must

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

၉

Examine sician and burial-trans physician the burial Completed by Physician/Medical as attending | signed by the at d be detached fo certificate has t irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be Certification: To

Division or Vital Records, P.O. Box 68760.

or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant

27. Manual of Death

5 Pending investigation

determined

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

STREET, BALTOMARE, OD 21211

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a, Certifier

Medical

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

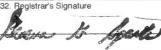
29d. Date signed (Month, Day, Year)

041 State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THABBLE MACSNEGOR, 700 W 40 M 31. Date filed (Month, Day, Year)

32. Registrar's Signature



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death		4000 10074
			Decedent's Name (First, Middle, Las	n	Outmoute of Douth	2. Date of Death	3. Time of Death
	Physici /Medic		John	Adam Mur	zert	April	Day 2008 11 30A.M
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	ith	4c. County of Death
			5. Social Security Number 6. Se	7. Age (In yrs. last b	FOREST HIL	S. 8 Date of Birth	Har ford
в	Funeral Director			ØM 2□F 9/	Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign Country) 9.7 Rollymore, MI
	pu *		Usual Residence of Decedent 10a. State 10b. County	100 City To	wn or Location		10d. Inside City Limits
	/anyla	õ	MA Hack	- A	Forast 4:11		1 ☐ Yes 2 No
	the h	rect	10e. Street and Number	1 Q	10f. Zip Code	10g.	Citizen of What Country?
	th with	ai D	1830 Cosner	Road.	21050		USA
	tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show eny injury or other treumatic event, I'm Medical Examination must be notified at once.		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Mr Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No Specify:		Specify: White
21215-0036	72 hou neture ical E	Completed by	15. Decedent's Ed (Specify only highest grad	ucation 16	a. Decedent's Usual Occupation (Give kind of work done during most of wo	16b.	Kind of Business/Industry
2	ithin he.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	W.	laryland Bi
2	tiled w Hygier other ti		17. Father's Name (First, Middle, Last)	1 (arpenter 18 Mother's Na	ame (First, Middle, Maid	hoot for the Dind.
an	should be tiled withir nd Mental Hygiene. marked other than imatic event, the Ma	To Be	Toho Mus	Tort	1000	Cookin	no bam
Maryland	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (T	ype, Print) 19	b. Mailing Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, Zip Code)
	1 and 2 Health em 27 i			-daughter 1	830 Cosner Rd.	Forest H	TI MD 21050.
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Disposition 2 Cremation 3	Removal from State	of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, State
量	permit. Page Department of Importent: If eny injury of		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	1/4/1/0	22. Name and Address of Facility	5/0 Y D	MORE MD
Ba	Departing Department of the policy in the po		Kux belli	Zechothu	Evans Funeral Cha	Del Hanna	tion Services Tarkuille
	S Carre		23a. Part . Enter the disease, or omp shock, or heart failure. List only	lic tons that caused the death. Do		or espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Congesti	e Heart I	gilure	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	0-0	- 127/2
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):	antel	ise
	ansit a	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Hype	& tension		
o,	cate be executed physician and the burial-transit	Exc	resulting in death) Last	Due to (or as a consequence	of):		
68760,		dical		d			
_	nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
P.O. Box	death e atte	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
<u>о</u>	nat the d by th etache	Physician/M	9 Unknown	9Ll Unknown			
g g	signer d be d	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death? No 3 Probably 4 Unknown
Records,	w require been si should t	Completed				24a. Was an	24b. Were autopsy findings available
	The la te has age 2	omp				autopsy performed	prior to completion of cause of death?
ta	ien: irtifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	No 1 Yes 2 No
<u>\</u>	hysic this ce	၉	1 □ Yes 21 No	Hospital: 1 Inpatient 2 ER/O		Home Residence	6 ☐Other (Specify)
on C	ding P	ion	27. Manner of Death Hatural 5 Pending		Time of Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division of Vital	Attence death	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f		28f. Location (Street	and Number or Rural Route Number,
	al or safter	Certification:	4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely titled in by the funeral director, page 2 should be detached for use as	Medical	Check only 2 Medicel Exem	ner: On the basis of examination a	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	o the ithin 2 o the omple	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d. [Date signed (Month, Day, Year)
ł	- \$ - 0		Milan A	10	D2539	7/ 4	1-4-2008
	211		30. Name and address of person who co		Ch Raven /	2/w/ 1.	1-4-2008 Bathinal m2123
	Sta	0	31. Date filed (Month, Day, Year)	32 Registrar's Signature	weredown 15	100	100111111111111111111111111111111111111
	Registr		APR 0 4 200		Charles		
DHI	MH 17 Rev 1/20	01	11111				

John Munzet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			Please Type of Print in Black Indelible Ink. Ensure		_	
			State of Maryland / Department of Health and	mental Hy	giene nn 8	10393
			Registrar Certificate of Death		Reg. No.	10000
0	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Year	3. Time of Death
	/Medic		Florence Gertrude Morgan	03	30 2008	
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Dea	th
	100		Laurelwood Care Center Elkton		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Da	th y, Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		215-07-5781 88 Yrs.	01/23/	1920 Ma	ryland
	and w		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryl f ehc	ö	MD Baltimore Baltimore			1 □Yes 2√□No
	the /	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	death with the Maryland ms 23e or 28a-f ehow rmest te notified at					
	leath	Funeral	8 Avery Court 21237 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No	U.S.A. 14. Race - Am	erican Indian,
10	fter d	듄	Armed Forces? If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Wh	te, etc.
38	urs a	5	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No II Yes Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify:	hite
Õ	2 ho	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	4.1	16b. Kind of Business	
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2	d wit	Completed	12 Production Analyst		Martin Mar	ietta Corp.
5	e file al Hy oth	Be		me (First, Middle,	Maiden Sumame)	•
<u> a</u>	Vid b	2	Vernon A. Riedel Bertha	a M. Bake	er	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Menial Hygiene. It health and Menial Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other treumatic event, it a Medical Exercity or must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	urai Route Numbe	er, City or Town, State,	Zip Code)
	permit. Pages 1 and 2 Depertment of Health a Important: If item 27 le eny injury or other tree		June A. Plummer (daughter) 3608 Day Road - Darl	lington.	Maryland	21034
Baltimore,	of He itan	4.5	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City o	
Ĕ	Page nent int: H		1∑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. 04/	02/2008	Baltimore	Maryland
二二	mit. pertin		21. Signature of Funeral Service Lisensee 22. Name and Address of Facility E.			
m	Depermination of the contract		C. Al Xassaln 11750 Belair Road			
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	-		Approximate Interval Between
	Physician		Immediate Cause (Final	15		Onset and Death
	/Medical	X 1	disease or condition resulting in death) a. Due to (or as a consequence of):			
	Examiner		1) 200 2 3 4			
	Programme and the second	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
128	cuted	Examiner	Cause (Disease or injury that initiated events c.			
ó	te be executed ysicien and ne burial-transit		resulting in death) Last Due to (or as a consequence of):			
1760	certificate be nding physicie use as the bur	cai	d			
68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE:			
Вох	th ce tendii r use	an/h	23b. Was decedent pregnant 23c. If yes, outcome or pregnancy		23d. Date of de	,
	ed fo	sici	in the past 12 menths? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
O.	at the by ti	h	9 Unknown			
Ś	es th gned be de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute	
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ပိ	law r as be 2 sh	pie	OCD	24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Œ	The ste h page	E		perfo	rmed? death?	s 2/2 No
ita	ian: ortific ctor.	Be C	25. Was case referred to medical 26. Place of De	ath (Check only o		
Division of Vital Records, P.O.	nysic nis ce direc	To	examiner? 1 Yes 2 No	Home 5 Resid	dence 6 □Other (Sp	ecify)
0	ter th		27. Manner of Death 1-Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
<u>Ö</u>	endii eath. or: A	Certification;	2 Accident investigation M 1 Yes 2 No			
Ξ̈́	r Att	ŧΪ	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (3 City or Tox	Street and Number or F wn, State)	ural Route Number,
۵	ital o	Cel				
	Hosp 4 hou Funs ely fii	edicai	29a. Certifier Certifying Physician/To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medical Examples: On the basis of examination and/or investigation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated, to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funars! Director: After this certificete has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Med	one) /and manner stated.		29d. Date signed (Mor	
	Vit Co		The Design			
			D54073		31 MAR 04)
	25		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A2UEN STUNE . MA RID (THURSTHAM STORMS CO.)	D. 1/4521-	DE 19	77,0
	7		APR 0 4 2008 APR 0 4 2008 APR 0 4 2008 APR 0 4 2008	TWWITE	DC 17	100
	Sta Registr		APR 0 4 2008			
		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIFY//27 per PHYS, C878 4/4/08 TS State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 0.0 Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day **Physician** 11:49 a HANTE Apr 1, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 801 West Winters Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F Director So. Carolina 246-20-2972 Jan 2, 1919 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 □ No Director **Baltimore** Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a (must b 801 West Winters Lane U.S.A. 21228 Funeral ural", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify Completed by 3 Widowed 4 Divorced Black 'natural", Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Campbell Soup Co. the **Employee** marked other artment of Health and Mental Hyg ortant: if Item 27 is marked other injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucille Rose Bucci Rose ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verlina Johnson Daughter 1100 Cooks Lane Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: if any injury or once. 04/05/08 Lansdowne, Maryland 4 Donation 5 Dother (Specify) Mt. Zion Cemetery of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 212 23a. Rant/ Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 800 a /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner burial-trar and The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 3 Probably 4 Unknown 2 □ No Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 : autopsy perform certificate 211No 1□ Yes funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 \subseteq Nursing Home 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) this 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? After 1 XNatural 5 ☐ Pending investigation Injury Hospital or Attendi 24 hours after death. Funeral Director: A 1 ☐ Yes 2 □ No 2 Accident filled in by the Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. STACY D. GARLETT-RAG29C. License number 29b. Signature and title of cortifier 29d. Date signed (Month. Day, Year) 2

Registrar
DHMH 17 Rev 1/2001

8

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THCY D. CARLETT-RAY, NO MOH, NEA

32. Registrar's Signature

Year)

4

31. Date filed (Month, Day,

APR 0

UN VER 4538

Edmuds 1111a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 2008 8:30 PM **Physician** Lori Lynn McNeil /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE HOSP STAGNES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 56 Yrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 □ F 220-38-9050 9-1-1951 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2□No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 S. Tremont Rd. 21229 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 N Married 2∐ No White 1 🗆 Yes Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Supervising Auditor <u>|Convenience Store</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Leushel Ruth J. Herschberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry McNeil Husband 108 S. Tremont Rd. Balto. Md.21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview 4 Donation 5 Dother (Specify) 4-4-2008 Balto.Md. 21. Signature of Empal Service Lives 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTAT Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sunsequence off Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be exect Box 68760 Ö Δ. Records, certificate Division or Vital To the Hospital or Attending Physician: After

Funeral

Director

28a-f show a or 28a-f shot be notified

items 23a

'natural', or

th and Mental

Department of Health Important: If item 27

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Funeral 12

State

Registrar

Medical

29b. Signature and title of certifier

29c. License number P 2 2 2 5 3

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

AMICHHANE DIMAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMICHHAVE, DIMAN 900 CATON AVENUE BALTIMORE

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

APR 04 2008





08-02553		Please Type or Print in Black Indelible Ink. Ensure All Copi		.egible.		
John Frank Magu		State of Maryland / Department of Health and Mental H 1-For State Registrar Certificate of Death	lygiene	Reg. No.	200	8 1039
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Toho FCAOK MAGNICE	2. Date of I Month March	Death Day 31, 2008	Year	3. Time of Death 1330 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 5764 Steven Forest Road Apartment 307 Columbia		4c. C	ounty of Death ward	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min	_	Birth(MM/DE	Foreign	nplace (State or ntry) I // no is
tith the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Columbia 10e. Street and Number 10f. Zip Code 57/04 State Forcest Pd #307 21045		10g. Citize	n of What Coun	10d. Inside City Limits 1 Yes 2 No try?
r death w	by Funeral L	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:	o Rican, etc.)	Sį	White, etc.	ian Indian, Black,
1215-0036 Id be filed within 72 hours after fental Hygiene. arked other than "natural", event, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name 18. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	etired)	Fel	leral (urname)	Government
21218 uld be file Mental H marked c	To Be	John Frank Maguire Sr. Lee 19a. Informan's Name/Relationship (Type, Print) / 19b. Mailing Address (Street and Number or	Rural Route	CKer Number, City	mann or Town, State,	Zip Code)
, MD 2 and 2 shou lealth and N tem 27 is n traumatic		Mr. Jim Maguire (Son) 19 Randall Ave.	Pa Date	1to. N	1d, 21	208
imore, Pages 1 ar ment of He tant: If ite		20a. Method of Disposition 2 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify:	15/200	08 B	alto.	Md.
		21. Signature of Funeral Service Licensee 22. Name and Address of Faculty 32. Name and Addres	heral Bar	to. Md	e, P. A	Approximate Interval
Physician /Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	or respirator,	y arrest, snoo	N, OI HOUR	Between Onset and Death
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.				
My. baltur ansit	ш	events resulting in death) Last Due to (or as a consequence of): d.				
0, s be exec	edica	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. There this certificate has been signed by the attending physician and optietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 2 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 5 Fetal death 5 Other (Specify) 9 Unknown 5 Other (Specify) 9 Unkn	nancy		Date of delivery	Day Year
P.O. It as that the gned by the detached	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Process.	the cause of death?
of Vital Records, ng Physician: The law require the true certificate has been si meral director, page 2 should b	Completed		-	Vas an outopsy performed?		topsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical 25. Mas				
n of Vi ding Physi n. After this funeral dir	ို	1 Ves 2 No rospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outel 4 Nurs 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Desc	Residen	ce 6 🗹 Other	: Scene
Division the Hospital or Attendinin 24 hours after death. the Funeral Director: /	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		on (Street an wn, State)	d Number or Ru	ral Route Number, City
the Hospital hin 24 hours the Funeral	lical C	29a. Certifier 1 Certifying Physician: Terthe best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred				

15 State 31. Date filed (Month Cay,

Registrar

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 1, 2008

30. Name and address of person who completed cause of death (Item 23a)

Chief Medical Examiner

32. Registrar's Signatur

29b. Signature and title of certifier

David Fowler M.D.

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Grane	5.7	107	0	1		U	1	

		1- For State Registrar		Ce	ertificate	e of l	Death			Reg		.Ut	0 100
Physic		Decedent's Name (First, Midd.	le,Last)							of Death			3. Time of Death
Amlical Exam	ine	Donald Walte	r McGloth	lin					Mon Mar	ch 30, 2	Day Year 008	<i>'</i>	1633 hrs
7		4a. Facility Name (if not institution	n, give street and n	umber)		4b	. City, Town, or L	ocation of D	Death		4c. County of	f Death	
		Oakington Road					Havre de Gra	ace			Harford		
Funeral		Social Security Number	6. Sex	7. Age (In yrs	. last birthda	ıy)	If Under 1 Year	If Under 24	4Hrs. 8. Da	ite of Birth	(MM/DD/YYYY)		nplace (State or
Director		213-60-5833	1 X M 2 F	ĺ	54	Yrs.	Months Days	Hours	Min.	Oct 1, 1953 Foreign			ntry) Maryland
		Usual Residence of Decedent	25	L			L			-L 19	1900		····
any		10a. State 10b. County		10c. Cit	y, Town or L	ocatio	n						10d. Inside City Limits
* · ·	_ ا	Maryland Har:	ford		۸b	erd	oon						1 Yes 2 X No
Aaryland 28a-f show 1 at once.	용	10e. Street and Number	LOLG		- 110		10f. Zip Code			10g. Citizen of What Cou			15.2
e Ma or 28	Director							.1					шуг
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		52 Liberty Str					2100				USA		
th w	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was De arried Armed F	cedent Ever in orces?	U.S. 13		Decedent of Hispa s, specify Cuban,				14. Race White		an Indian, Black,
5 PE	F		1 Yes	2 X No			Tea.						
s after	ğ	45 0	orced If Yes, Give Ye or Dates:		1 1		res 2 X No				Specify:	Whi	
hour natu Exar	ted	15. Decedent's Education (Specific Elementary/Secondary (0-12)					S Usual Occupation of working life. I			ne 1	6b. Kind of Bus	iness/In	idustry
)36 hin 72 than edical	Completed	11	College (1-4 or 5+)		Doi	nter			- 1	Colf	Emm 7	laved
With with her t	E	17. Father's Name (First, Middle,	Last			гал		S de de ente & l	lama (First)	4: 1-11 - 11-	Self		Loyed
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	Be C	Guy T. McGlo					"		· ·		iden Surname)		
212 212 Menta Mark mark	O B	19a. Informant's Name/Relations			10b M	lailing 4	Address (Street		ary Be		or City or Toyer	Ctoto	7:- 0
MD to 2 shot tith and 1 is 1 is 1 is 1 is 1 is 1 is 1 is 1 i	-	Jeffrey Newma		d			berty St						
nore, MD 21215-0036 sges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If I fliem 27 is marked other than "natural", or items 23a or 28a-f shu other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition	all, LLICIP				on (Name of ceme		Date		20c. Location -		
Ore		1 Burial 2 X Cremation	3 Removal f	rom State	crematory	or othe	r place)						
F. B. P. F.	1	4 Donation 5 Other Sc		Me			atory In	c. (04/03/	08	Baltim	ore,	Maryland
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med injury or other traumatic event, the Med		21. Signature of Funeral Service		0	- 1	22 Nar	me and Address of EMATION	Facility SOCIE	tv Of	Mary]	land. I	nc.	
		Thomas Gregor	ral Service Licensee 22 Name and Address of Facility Cremation Society Of Maryla 299 Frederick Road Baltimor disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s										and 21228
Physician Medical		failure. List only one cause	one cause on each line.									Approximate Interval Between Onset and	
_xaminer		Immediate Cause (Final disease	a. Drowning o			therm	ia						Death
		or condition resulting in death)	Due to (or as a	consequence	of):								
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Sox 68 leath certi e attending for use as	ciar	past 12 months?	LITIVE	ointh nant at time of d				Ectopic pre	egnancy		Month	Da	ay Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unk	nown g Unkn		eath 5	Othe	r (Specify)						
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tal Records, P.O.	d by								1	Yes	2 ✔ No 3	Proba	bly 4 Unknown
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COI law has l	Id I								- _	autopsy _ performe		rior to co eath?	mpletion of cause of
	ပ္ပ									Yes 2	No 1	✓ Yes	2 No
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of Vital Records, ng Physician: The law requir the this certificate has been si meral director, page 2 should b	T ₀	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpat				ursing Home		sidence 6		Scene
~ ⊆ . ^ ≥ l	ü.	1 Noticed	28a. Date	, Day, Year)	28b. Time FOUND				Subjec	escribe how ct drown	vinjury occurre ed in cold e	.a ∋nviror	nment
Sio Arten deatl sctor:	cati		tigation Mar 30,	2008	1505 hrs	3		s 2 V No					
Division tall or Attending after death.	ŧ		not be 28e. Plac mined (Specify)	e of Injury - At I しし	nome, farm. IMのSWI	street,	factory, office buil	Iding, etc.	28f. Loc	cation (Stre Town, State	eet and Number e) , Havre de G	r or Rura	Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Se	4 Homicide	(оресну)	River				.,	Oaking				
he H in 24 he Fr	g	(Check only 1 Certifying PM one) 2 Medical Exam	ysician: To the bes										
To the within 2 To the complet	Medical Certification:	29b. Signature and title of certifie	and manner s	tated.		ga.IVI	· · · · · · · · · · · · · · · · · · ·		os actine till				
	2	250. Signature and this divertifie	1 -				29c. License r				9d. Date signed		n, Day, Year)
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							O.C.M.	.c.		^	March 31, 2	บบช	
OCME		30. Name and ad 7 ss of Jerson v				144 -	Donn Ct	7-14:	140 010	04			
			Deputy Chief N			111 F	Penn Street, E	aitimore	, IVID 212				
St Regist		31. Date filed (Month, Day, Year) APR 0.4.2	797	egistrar's Signat	ure	and a	1	1		er e fin			9 5
			A Section As the Section of the Sect	many Mary	A.C. W. Sept. 1987	NA STREET							

08-02249	
Joseph Newman	

oseph Newman	otate of that Justice Department of Freeholder 1981									
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death							
Medical Examine	Joseph Lagar	Newman	Month Day Year 1040 hrs							
	4a. Facility Name (if not institution, give street and number) 9340 Crain Hwy #126	4b. City, Town, or Location of D Bryans Road	eath 4c. County of Death Charles							
Funeral		(In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Foreign							
Director	228-74-0468 ₁ X _{M 2} F	57 Yrs. Month's Days Hours	Sept 20, 1950 Country VA							
, we	Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Location	10d. Inside City Limits							
faryland 28a-f show any at once. ector	MD Prince George's	Upper Marlboro	1 X Yes 2 No							
Dir the N	10e. Street and Number 206 Bedjay Drive	10f. Zip Code 20774	10g. Citizen of What Country? USA							
death with r items 23 nust be no uneral	11. Marital Status 1 Never Married 2 Married Armed Forces?	ver in U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu								
fer dea	1 Yes 2 X	X No 1 Yes 2 X No specify:	Specify: Black							
ours after a francing	15. Decedent's Education (Specify only highest grade comp	of work done 16b. Kind of Business/Industry								
5-0036 ed within 72 hours tygiene, other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5-	during most of working life. DO NOT use Financial Auditor	US Commerce Dept.							
OOC I withi giene, iher the e Med	17. Father's Name (First, Middle, Last)		lame (First, Middle, Maiden Surname)							
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica To Be Comple	Belvie William Newman	Rogers								
MD 21 d 2 should th and Me n 27 is ma ummatic ev	19a. Informant's Name/Relationship (Type, Print) Arliss R. NEwman - Brother	19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code) n. Raleigh. NC 27603							
e, M and 2 Fealth ricen 2 traun	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State							
nore ages l nt of F nt: If i	1 X Burial 2 Cremation 3 Removal from Stat	e crematory or other place) Dan River Bethel Bapt Ch.	3/28/08 South Boston, VA							
Baltimore, permit. Pages I ar Department of Hee Important: If ite	4 Donation 5 Other Specify: 21. Signatur of Funeral Service-Licensee	2000 N. Main Street								
ii. II. De m	Juen Brendl	Jeffress Funera								
Physician 'Medical	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.		ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death							
kaminer	Immediate Cause (Final disease or condition resulting in death) a.Cirrhosis of Due to (or as a consection)		2000							
<u> </u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec	anence of).								
ited ansit Examiner	Couse. Enter Underlying Couse (Disease or injury that initiated									
ecuted and transit	events resulting in death) Last Due to (or as a consect d.	quence of):								
dician sees	X UNPENDED AMENDED 23a,2	27 per ME g878 5/1/08 amh								
	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome	□ =	23d. Date of delivery equancy Month Day Year							
car 68760, earl certificate beath certificate by attending physical for use as the bursician/Mec	past 12 months? 4 Pregnant at ti	2								
). Bo) the death by the att ached for Physi	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?							
by detr			1 Yes 2 No 3 Probably 4 Unknown							
ords, w requir s been s should			24a. Was an autopsy findings available prior to completion of cause of							
Records, I The law requires if freate has been sign, page 2 should be Completed										
Vital Rec ysician: The list certificate list director, page	25. Was case referred to medical	26.Place of Death (Cr	eck only one)							
f Vid	examiner? 1 Ves 2 No Hospital: 1 Inpatien 27. Manner of Death 28a. Date of Injur		ursing Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred							
Division of N spital or Attending Ph. tours after death. neral Director: After ti filled in by the funeral Certification: T	1 X Natural 5 Pending (Month, Day,Yei	ar) 1 Yes 2 No								
ivision or Attendate death Director:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
DIVI Spital or nours afte neral Dir filled in	4 Homicide determined (Specify)		or rown, state)							
To the Hospital within 24 hours To the Funeral completely filler	one) 2 Medical Examiner: On the basis of exam	knowledge, death occurred at the time, date and place ination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)							
To cont	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
<i>[6]</i>	Waynie Me While	O.C.M.E.	March 22, 2008							
100	30. Name and address of person who completed cause of de		AD 24204							
ON	Margarita Korell MD. Assistant Medical E 31. Date filed (Month, Day, Year) 32. Registrar's		∠ 1∠UT							
State	31. Date filed (Month, Day, Year) 32 Registrar's	o digitation								

ORIGINAL

08-02449 Viola Naylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ola Naylor		1- For State	of Marylan		rtment of			Menta	Hygier		No 20	08	1089	
Physicia		Registrar 1. Decedent's Name (First, Middle,La	st) Viola Mar				_			Reg. e of Death		3. Ti	ime of Death	
ediçal Exami			Viola		Nay	lor			Mor Mar	nth rch 28, 2	008 Year	1	136 hrs	
		4a. Facility Name (if not institution, gi		er)	41			cation of D	eath		4c. County of De			
		4025 Frederick Avenue,				Baltimore						N/A		
Funeral		5. Social Security Number 6. S	Sex 7.	Age (In yrs. la	ast birthday)	If Under Months		If Under 2 Hours	4Hrs. 8. Da Min.	ate of Birth	(MM/DD/YYYY) 9. Fo	Birthplac reign	e (State or	
Director		214-64-9153	M 2X F	58	Yrs.	WOTHERS	Days	riours	Jı	aly 5	,1949	Country)) MD	
».		Usual Residence of Decedent 10a. State 10b. County		lan- cir.	Town or Locatio							104	. Inside City Limits	
ow any			17	Too. City,	Town or Locatio	м							Yes 2 No	
Maryland 28a-f show d at once.	tor	MD N	/A			10f. Zip C		timor	e City		. Citizen of What 0			
th the Maryland 23a or 28a-f sho	Director					TOI. ZIP C	oue					-		
after death with the Maryland ral", or items 23a or 28a-f she iner must be notified at once		4025 Frederic	k Avenue	Apt.		Docodoni		229	(Specify Y			ited States 14. Race - American Indian, Black,		
ath w	Funeral	1 Never Married 2 Marrie	A	es?					uerto Rican,		White, et		idiali, black,	
rer de		3 Widowed 4 Divorce	1 Yes ed If Yes, Give Year							Specify:	Wh	nite		
2 hours afte "natural",	d by	15. Decedent's Education (Specify	or Dates:	completed)	16a. Decedent	's Usual O	ccupatio	n (Give kin		ne 1	16b. Kind of Busine	ess/Indus	try	
											1			
5-0036 led within 7/ tygiene. other than	Completed	8 Years			De	pende	ent				N/A			
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin		17. Father's Name (First, Middle, Las		C	18.Mother's Name (First, Mid					Middle, Ma	aiden Surname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Walter Herber		Ы.			_		Mildre	ed Har	mony			
MD 2 d 2 shoul lith and M n 27 is m aumatic	은	19a. Informant's Name/Relationship	`								er, City or Town, S			
3 g g g g		Mr. Walter H. Na 20a. Method of Disposition	aylor (Bro		823 . Place of Disposit				Balt		Maryla 20c. Location - Cit		21222 n, State	
Baltimore, permit. Pages I an Department of Her important: If ite	П	1 Burial 2 X Cremation 3	Removal from	State	crematory or other									
Baltimo permit. Page Department o Important: injury or ott		4 Donation 5 Other Specification of Funeral Service Lice		Hi	lltop S	ervic ame and A			1/1/20	008	Towson	, Ma	ryland	
Ba perm Depa Impo	W				D1	uda-F	luck	Fune	cal Ho	me of	Dundalk Maryland	. Ty	وركيا	
Physician		23a. Part I. Enter the disease, or com		sed the death	. Do not enter the	e mode of	use dying, sı	uch as card	liac or respi	ratory arres	t, shock, or heart	Ar	oproximate Interval	
'Medical		failure. List only one cause on a Immediate Cause (Final disease		sorder (complicat	ine hv	perte	nsive	cardio	vascula	ar disease	В	etween Onset and Death	
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Seizure disorder complicating hypertensive cardiovascular disease Due to (or as a consequence of):													
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	2222222222	f).			_				+		
	nine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a co	onsequence o	1).									
198 = =	Examiner	events resulting in death) Last	Due to (or as a co	onsequence o	f):									
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so, te be ex ysician	ledi	IF FEMALE:	23a, 27, 28a 23c. If yes, out			9/08 T	Τ #.	rberne			23d. Date of del			
Box 68760, e death certificate be the attending physic ed for use as the buri	N/N	23b. Was decedent pregnant in the past 12 months?	1 Live birti			al death	3	Ectopic p	regnancy		Month	Day	Year	
ox 6 ath cer	sicia	1 Yes 2 No 9 Unknow		t at time of de	eath 5 Oth	er (Speci	fy)							
be de	Physician/M	Part II. Other significant conditions	9 Unknow		onulting in the ur	ndorlying	nauco aix	on in Dart	2	3e Did tob	acco use contribut	e to the	cause of death?	
cords, P.O. Box law requires that the death has been signed by the atte should be detached for u	by	art in Other Significant Conditions	contributing to a	eath but not r	esaling in the di	ilderlying t	duse giv	ici, iii i ait		, married	2 No 3			
ords, P.C. w requires that is been signed to should be deta	Completed								— L	24a. Was ar			y findings available	
	nple				·					autops: perform			eletion of cause of	
tal Rection: The	Co							75 0 16		✓ Yes 2	No 1 ✓	Yes	2 No	
ital ician: s certi	Be	25. Was case referred to medical examiner?	Hospital:	atient 2	ER/Outpatient	r	10	thor:	heck only or Nursing Hom		Residence 6 🗸	Othor: So.	000	
ion of Vital tending Physician: eath. for: After this certif the funeral director,	ဥ	1 Yes 2 No 27. Manner of Death	28a. Date of		28b. Time of In			at Work?			ow injury occurred	7(1)61.000	316	
nding th.	ion	1 Natural 5 Pending	(Month, D	ay,Year)	1 2012		1 Ye	s 2 N	0	.1_				
ivision or Attendather death Director:	fica	2 Accident Investigat 3 Suicide (XX) Could no	290 Place 6	of Injury - At h	unk ome, farm, stree						reet and Number of	or Rural F	Route Number, City	
227. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Pending Investigation 2 Representation 3 Suicide 4 Homicide 5 Pending Investigation 2 Representation 3 Suicide 4 Homicide 5 Pending Investigation 4 Homicide 5 Pending Investigation 3 Suicide 6 Pending Investigation 3 Suicide 6 Pending Investigation 4 Homicide 5 Pending Investigation 5 Pending Investigation 6 Pending Investigation 6 Pending Investigation 7 Pending Investigation 8 Pending Investigation 9 Pendi									or Town, Sta 1 k	ate)				
Ho Fur			cian: To the best of											
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examin	er:On the basis of and manner stat	examination a ed.	ind/or investigati		License		neo at the t	ime, date a				
	2	29b. Signature and title of certifier	200 3/				O.C.M				29d. Date signed March 29, 20	•	рау, теаг)	
,		Jasha A					U.U.IV	·· L ·			IVIAIOII 28, 20			
\$		30. Name and address of person who Tasha Greenberg MD.	o completed cause Assistant Med			Penn St	reet. B	Baltimore	e, MD 212	201				
·	ate	31. Date filed (Month, Day, Year)		strar's Signati	uro d									
Regist		APR 0 4 20	08	a 18.	Apart.									

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buttors after death.
To the Elimenal Director after this conflictor has been simpled to the conflictor of the conflictor o Division of Vital Records, P.O. Box 68760,

		1 - State Registrar	Ce	ertificate of		F	Reg. No 2008		
Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Wallace S. No:	rth, Jr.			2. Date of Dea Month April	Day Year	3. Time of Death 10:15 p ^M	
/Medi Exami		4a. Facility Name (If not institution, give street and numb	er)		r Location of Death	при	4c. County of Dea	th	
Funeral	H	Gilchrist 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday	Tows	If Under 24 Hrs.	8 Date of Birth	Balti		
Director		215-30-6130 ¹ 反 M 2□ F	75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan 17	h y, Year) 9. Birthplace (State or Foreig Country) Maryland		
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
ne Mar 8a-f sh	ctor	Md. Baltimore	Towson					1 □Yes 2 No	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Madical Evantion. Limit be in titled at once.	Funeral Director	10e. Street and Number 205 E. Joppa Rd. #1101		10f. Zip Code 21 2	86		log. Citizen of What Co		
ter deg	Fune	11. Marital Status 1 □ Never Married 2 ⋈ Married 1 □ Never Married 2 ⋈ Married	s?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	fy Yes or No- can, etc.) 14. Race - American Black, White, etc.		
ours af	Ď	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 If Yes, Give Year or Date	s:	1 □Yes 2 No	Specify:		Specify:	White	
in 72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of worki	ng	16b. Kind of Business	Industry	
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l be file intal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)		
should ind Me mark umatic	은	Wallace S. North, Sr. 19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street		oies al Route Numbe	r, City or Town, State, 2	Zip Code)	
and 2 ealth a m 27 is	3	Mrs. Betty Lee North/ Wife	20	5 Е. Јорр	a Rd. #11		on, Md. 212		
ages 1 nt of H t: If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	le i	osition (Name of ematory or other plac		ate	20c. Location - City or		
mit. Partme bartme cortant injury		4 □ Donation 5 ☑ Other (Specify Entombme 21. Signature of Funeral Service Licensee		Valley Men 22. Name and Addres		08	Timonium,	Md.	
Imp Dep any any any any		· CHICA		Ruck To	wson Fune rk Rd. To	ral Home	e, Inc. d. 21204		
		23a. Part 1. Enter the disease, or commications that cause shock, or heart failure. List only one cause on each	sed the death. Do not en line.	nter the mode of dyin	g, such as cardiac c	or respiratory arr	est,	Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	as a consequence of):	unair				Crisci and Beam	
Examiner			as a consequence oi).						
nsit	Medical Examiner	Sequentially list conditions, if any leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of:						
execu an and rial-tra	Еха	that initiated events resulting in death) Last C Due to (or	as a consequence of):						
cate be ohysici the bu	dical	d							
nding use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor	ne of pregnancy	_			23d, Date of del	han	
ed for	Physician/	in the past 12 months? 1 ☐ Live birti	t at time of death 5	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	/ 		Month	Day Year	
hat the ed by ti detach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death		undarlying course give	on in Part I	220 Did tol	pacco use contribute to	the source of death?	
uires t n signe ild be o	d by	Takin, Since significant containing to dead	but not resulting in the u	indenying cause give	en in Pari I.	23€. Did tot	\checkmark	obably 4 🗆 Unknown	
law rec as bee 2 shou	Completed		-			24a. Was a		topsy findings available	
: The cate har page	Com					autops perform 1 □ Yes 2	ged? death?	completion of cause of 2 □ No	
sician certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inperior		nt 3 DOA Othe	26. Place of Death	(Check only on	e)	6	
ng Phy ter this neral d	n: To	27. Manner of Death 28a. Date of It	ntient 2 ER/Outpatien njury 28b. Time o Day, Year) Injury	III 3 LI DOA	4 ∐ Nursing Hon		ence 6 Dother (Special winjury occurred	city) Vlos plue	
tendir seath. tor: Al the fur	catic	2 Accident investigation		M 1 🗆 1	res 2□No				
al or Al after of Direct d in by	Certification: To	determined 286. Place of I	njury - At home, farm, str etc. (Specify)	reet, factory, office	2	8f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical C	29a. Certifier (Check only one) Certifying Physician: To the besidence on the property of the	of examination and/or in	th occurred at the tin	ne, date and place, a pinion, death occurre	and due to the cared at the time, day	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
To the within To the compl	Me	29b. Signature and title of certifier		29c. License		29	9d. Date signed (Month	n, Day, Year)	
		> Whalim			58303	1	for 22	7008	
10+1		30. Name and address of person who completed cause of	6701 N-C	Print)	+ Pour	ariv	21204		
Stat Registra		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	ast.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29, 2008 **Physician** D. Benjamin 0wens March 5:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City, Town, or Location of Death Examiner Cherry Lane Nursing Home Laurel Prince George 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 247-07-4633 M 2 □ F 96 Director 25. 1911 South Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Director Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1568 Farlow Avenue 21114 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder Welding Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin 0wens Rowena Pacettie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Phillip Stradley/Friend 1568 Farlow Avenue Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 04-04-2008 Shallotte, N.Carolina 4 ☐ Donation 5 ☐ Other (Specify) Brunswick Mem. Gdns. 22. Name and Address of Facility Duda-Ruck F.H.of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Azterio /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No ate has t page 2 s autopsy performed? Yes 2 No certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 으 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar DHMH 17 Rev 1/2001

12

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SANDIA

APR 0 4 2008

14333 LAUNEL BOWLE

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year **Physician** March 25, 3:30 PM M Sigmund Polaczynski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. NoV 5, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F 271-03-4935 93 Cleveland, OH Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 'natural", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 10401 Logan Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any finury or other traumatic event, the Medical Examiner any inlury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify. 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cold Roll Operator Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Polaczynski Bernice Zenowicz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Consilvio - Daughter 10401 Logan Dr. Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removal from State 3/27/08 Cuyahoga Heights, OH 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 6505 Brecksville Rd. 21. Signature of Funeral SerVice Licensee Independence, OH 44131 Vodrazka Funeral Home 23a. Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between 2 days nmediate Cause (Final sease or condition sulting in death) Hypotension **Physician** /Medical Due to (or as a consequence of): Examiner Pulseless Electrical Activity 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician and defached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2K No 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 124 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 26, 2008 Maliance D006600

Registrar DHMH 17 Rev 1/2001

State

20814

Bethesda, MD

8600 Old Georgetown Rd.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helina Kassahun, MD

31. Date filed (Month, Day, Year)

		1 - State amend #19a Pe 1. Decedent's Name (First, Middle, Last)			19/108te	-			of Death		3. Time of Death	
Physici		Norman Eric Poirer						Mar	ch 22	Day 2008 Yes		
/Medic		4a. Facility Name (If not institution, give stree	t and number)		4b. City, T	own, or	Location o			4c. County of D	eath	
		260 E. 16th Street				deri				Frederi	ck	
Funeral Director		5. Social Security Number 6. Sex 1 M	0 □ E	rs. last birthday) 74 Yrs.	If Under Months	Days	If Under a		of Birth oth Day, Y	934 Cor	Birthplace (State or Foreig Country) Inecticut	
A H		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation						10d. Inside City Limits	
i e i e i e i e i e i e i e i e i e i e	ō	MD Frederick		Frederi	ck					1 ☐ Yes 2 ☑ No		
7 280 Inchi	Director	10e. Street and Number			10f. Zip	Code			10g	. Citizen of What	Country?	
23a o	<u>a</u>	260 E. 16th Street				2	1701			USA		
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Cal	Completed	15. Decedent's Educatio		16a. Dece	dent's Usual	Occupa	tion	t of working	16	16b. Kind of Business/Industry		
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natic	မ	Eric James Poirier Elise Richard 19a. Informant's Name/Relationship Type Rich. 19b. Mailing Address (Street and Number or Bural Boute Number, City or Tow								St Town Con	7:- 0-1-1	
treur		19a. Informant's Name/Relationship Type of Lori Poirier/speuse	iter		-			eet hage		-	21740	
ry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remore 4 ☒ Donation _ 5 □ Orther (Specify)	201	p. Place of Dispo cemetery, crer	sition (Nam	e of	-	Date	,	c. Location - City		
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	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	PAILUP Due to (or as a cons	sequence of):	0 1	HR	NE					
or use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	gnancy cify)				23d. Date of Month	delivery Day Year				
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aga 2 should t	Completed								. Was an autopsy performe	d? death	autopsy findings available to completion of cause of 1? Yes 2 X No	
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rns cermicere nas al director, paga 2	To	examiner? 1 Yes 2 No Hospi	al: 1 ☐ Inpatient 2	☐ ER/Outpatien	it 3 DO	Othe	r: 4 Nu	rsing Home 5	Residenc	e 6 Other (5	Specify)	
Je L		1 Natural 5 Pending investigation	a. Date of Injury (Month, Day Year,	28b. Time of Injury	M 28	C. Injury Work		28d. Des		injury occurred P/A		
completely filled in by the funeral	Certification:	4 Homicide	le. Place of Injury - Al building, etc. (Spe	PCify)	1A			City	or Town, 3	State)	Rural Route Number,	
completely filled in by the fu	edical		n: To the best of my k On the basis of exam and manner stated.	knowledge, death ination and/or in-	occurred a vestigation,	t the tim in my op	e, date and inion, deat	d place, and due th occurred at the	to the caus time, date	se(s) and manner and place, and	as stated. due to the cause(s)	
01 E03	Σ	29b. Signature and title of certifier			number	- 1		. Date signed (M				
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		30. Name and address of person who comple		IU TOI	Print) Ho	1152	- An	F. Fr	EDEY	UCK, H	2008 D 21701	
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DHMH 17 Rev 1/2001

			1 - For Sta	ate of Maryland /	Departn		ealth and I	Mental Hygie	ene na 8	10904		
			Hegistrer 1. Decedent's Name (First, Middle, Last)		Certiff	cale of L		2. Date of Death	j. No.	2 Time of Donth		
П	Physici	an	Tilsech Pit	<u></u>				Month 03	Day Year	3. Time of Death		
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	Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs. last b	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	(ear) 9. Bi	irthplace (State or Foreign Country)		
	Director		224-22-2431 21	83	Yrs.			(Month, Day,) Mar 11,	1925 Vir	ginia		
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	aryla sho	_		Toc. City, Tov						10d. Inside City Limits		
	Ba-f	Sct	MD		Balti	more				1X Yes 2 No		
	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28a-f show than "neturel" or items 23e or 28a-f show the Maryleal Exercities must be notified at	Director	10e. Street and Number		10	of. Zip Code	01000	100	J. Citizen of What C	Country?		
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Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	,			
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ar	short and and and and and and and and and and		19a. Informant's Name/Relationship (Type, Pr	int) 191	b. Mailing Ad	dress (Street ar	nd Number or Ru	ral Route Number, (city or Town, State,	Zip Code)		
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			James 11 CC	all	□Balt	imore.	MD 2120)1				
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	/Medical		resulting in death)	Due to (or as a consequence	of):							
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_		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):							
	cuted	in in	Cause (Disease or injury that initiated events									
ó	le be executed ysician and e burial-transit	Ě	resulting in death) Last	Due to (or as a consequence	of):							
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Вох	death certifica e attending ph id for use as th	Physician/Med		es, outcome of pregnancy					23d. Date of de	eliverv		
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₾	res that the de	E /	Part II. Other significant conditions contribution	ng to death but not resulting i	in the underly	ring cause given	in Part I.	23e. Did toba	cco use contribute	to the cause of death?		
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ě	has l	Idu				<u> </u>		24a. Was an autopsy	prior to	autopsy findings available completion of cause of		
		Co						performe 1 ☐ Yes 2	d? death? No 1 ☐ Ye			
Vital	Physicien: r this certifica ral director,	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)				
	nysic nis ca	2	1 ☐ Yes 2 ☐ No Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Oi	utpatient 3	DOA Other	4 Volursing He	ome 5 Residence	e 6 Other (Sp.	ecify)		
סר	ng Pi	ü	TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPER		Time of Injury	28c. Injury a Work?	at	28d. Describe how	injury occurred			
Division	Attending or death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		s 2 No					
<u>s</u>	Atte	100	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	Place of Injury - At home, fa	arm, street, fa	actory, office				Rural Route Number,		
ā	afte safte	Certification:	4 - Homelde	building, etc. (Specify)				City or Town, S	натө)			
	spito nours nera / fille		29a. Certifier 1 Certifying Physicien:	To the best of my knowledge	e, death occu	urred at the time	, date and place,	and due to the caus	se(s) and manner a	as stated.		
	To the Mospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examiner: Or	n the basis of examination ar d manner stated.	nd/or investig	ation, in my opir	nion, death occur	red at the time, date	and place, and du	e to the cause(s)		
	To th To th Comp	M	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Mon	oth, Day, Year)		
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							, , ,	•	wkut or	- I W-B		
			30. Name and address e on who complete	d cause of death (Item 23a)	(Type, Print)	20)	2-Atim	, ma) s	1000			
			31. Date filed (Month, Day, Year)	32. Poĝistrar's Signature,		2-1		٠	VWC			
	Sta Registra		APR 0 4 2008	Personal Solgitature	Sos	eles.						
	riogistii		711.11 0 1 2500	1	3							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 31, Day 2008 12:42 P^{M} Arthur Edward Pascoe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Months Days DOM 2□ F 172-16-6109 June 7, Pennsylvania 1922 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 U.S.A. 1824 Middleborough Road 12. Was Decedent Ever in U.S. Armed Forces? NEX 2 □ No 194 If Yes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1940-1 Never Married 200 Married 1 ☐ Yes 25 No Specify: Specify: White 3 Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ellen Lilly Philip Pascoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1824 Middleborough Road, Baltimore, Maryland 21221 Patricia McKinney (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 04/04/2008 Manchester, Maryland Millers U.M. Church 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 Wo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

23a

or items

"natural",

12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Director

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Completed

Be

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other traumatic event, the Medical Examiner must be notified at

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3/31/08

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

The law requires that the

ossce,

/Medical

Examine attending physician and for use as the burial-transit Physician/Medical ned by the a e detached for 2 should b Completed cate has page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification:

 $\mathfrak{F}_{ imes_{I}}$

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

27. Manner of Death

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 164395

29d. Date signed (Month, Day, Year) MARCH 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHAPLES ST. SUITE 209 BALTIMORE, MD 21204 DOBERMAN. MD DANIEUE

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 0 4 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Emmanue 08 /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saltimore Plnai Hospita altimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Funeral Days Hours 15 Director 218-35-4372 April 27,1992 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 🏋 🕅 No must be notified Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 1 Rozina Court 21117 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes XIXNo If Yes, Give Year or Dates: Never Married 2 Married ò Redc, Brandon Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ Specify. Black 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student High School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eric Peele Jessie (Isogon) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Peele / Father Rozina Court; Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ott
once. XIX Burial 2 Cremation 3 Removal from State All Saints Cemetery 4/5/08 4 ☐ Donation 5 Other (Specify) Reisterstown, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Uneral Service Licens westeres 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** esmodastk Smorths /Medical Due to was a consequence of **Examiner** uxels Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence oi) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) a∏Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes certificate 2 □ No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signa ture and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 0 4 2008

2401 W

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Smai Hospital

ND H006325

Belvedere Ave, Baltomore, MD 21215

		1- For State of Maryland		artment <i>tificate</i>			d Menta		ene () (38	10907
Physic	ian	1. Decedent's Name (First, Middle, Last) Elsie Marie		Polan	d			e of Death	3, Day 200	8 Year	3. Time of Death 7:10AM
/Med Exami		4a. Facility Name (If not institution, give street and number) Bradford Oaks Nursing Home			Town, or l	Location of D		Prtino			George's
, Funeral Director	v .	5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 K F 91 Usual Residence of Decedent	st birthday) Yrs.	If Under Months	1 Year Days	Hours N	Min. 8. Dat	e of Birth orth, Gay Y 10	19 16	9. Birth: Cour Cat1	place (State or Foreign ntry) ett, VA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show eny injury or other treumatic event, the Modral Examinar must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Maryland Prince George's 10e. Street and Number 8600 Mike Shapiro Drive #307 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13 Mever Married 12 Married 13 Mever Married 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 17. Father's Name (First, Middle, Last) Robert Henry King 19a. Informant's Name/Relationship (Type, Print) David L.Poland (Son)	spanic Origin? (Specify Yes or No- h, Mexican, Puerto Rican, etc.) Specify: tion uring most of working Home 18. Mother's Name (First, Middle, Maiden Sumame Minnie Ann Moore Ind Number or Rural Route Number, City or Town, S Iill Road Temple Hills,			What Cour. S.A. ce - Ameriack, White, fy: Business/Irr me) n, State, Zij Mary	can Indian, etc. White Industry				
Baltimore, permit. Pages 1 at Department of Hee Importent: If item eny injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Fureral Service Licensee	Lee l	B Funer rry R	Waldor al Hom oad Cl	f, Ma	aryland				
Ox 68760, Certificate be executed Water Manage physician and care ithe buriat-transit as as the buriat-transit		23a. Pan 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque c	ence of):	4	0 01 07 11 9	, 600112002					Interval Between Onset and Death
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Sion of tending Physeath. For: After this	Certification; To Be	25. Was case referred to medical examiner? Yes 2	28b. Time o Injury	of M	28c. Injury Work	at Vurs	28f. Lo	Reside	nce 6 00 w injury occi	urred	ral Route Number,
the Hospite nin 24 hours the Funerel	edical		rledge, deat on and/or in	nvestigation	, in my op	pinion, death	place, and du occurred at t	he time, da	ate and place	and due	stated. to the cause(s)
To t To t	M	29b. Signature and title of certifier Wella G. James w			D 35			1	_		
<i>5</i>	itate	31 Date filed (Month Day Year) 32 Ministrar's Signatu	23a) (Type,	Print)	sha	- Roma	A Fi	th	ASKIN	Jus.	8, 2008 MM J fort.
Regis		APR 0 4 2008	The state of the s								

		For	State of Marylan					nd Mer	ntal Hygi	ene	
	1	State Registrar		Cei	rtifica	te of i	Death		Re	g. No.2 () () 8	10908
Physicia		1. Decedent's Name (First, Middle, Last) Thelma Mae Pie	rce						Date of Death Month arch 29	Day 2008 Year	3. Time of Death 10:00A ^M
/Medica	. "	4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, or	Location of E			4c. County of Death	
		3500 Dixon Stree	t				Hills,			Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 138 14 0795	7. Age (In yrs. 93	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day, July 25	(Year) 9. Birth Coo	nplace (State or Foreign untry) I Jersey
5.5		Usual Residence of Decedent	140.00	. 7							10d. Inside City Limits
arylar show d at	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					all department	1 ☐ Yes 2 ☐ No
ne Ma Ba-f	Director	Maryland Prince Ge	orge's	Temp1					10	Og. Citizen of What Co	XX
with the	בֿ	10e. Street and Number				ip Code			"		
eath with the Marylar ns 23a or 28a-f show must be notified at	era	3500 Dixon Stree	2. Was Decedent Ever in U.	S. 13.	207 Was Dec		lispanic Origin	n? (Specify	Yes or No-	United St 14. Race - Amer	
ter d	by Funeral	1 □ Never Married 2 □ Married 3 📆 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, sp 1 ☐ Yes	ecify Cuba	an, Mexican, F Specify:	Puèrto Ric	an, etc.)	Black, White	e, etc. uite
-00 2 hour	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry									ndustry	
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Maryland 21215-0036 to 2 should be filed within 72 hours af this and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami		19a. Informant's Name/Relationship (Type			•					City or Town, State, 2	
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Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or othe page.		20a, Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ R		Place of Dispo cemetery, cre						01.	MD
timer rtmer rtant:		4 □ Donation 5 □ Other (Specify)	lLee	Crema	atory	Mar	ch 31.	2008	7	Home, Inc.	6622 014
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce.		21. Sign sure of Juneral Servi & License	son 96.	3 A	Lexar	ndria	Ferry	Road	l, Clír	iton, MD 2	0735
		23a. Part1. Enter the discase or complishock, or heart failure. List only or	cations that caused the deat le cause on each line.	h. Do not en	r the m	ode of dyli	ng, such as ca	ardiac or re	espiratory arre	est,	Approximate Interval Between Onset and Death
Physician		Immediate C use (First disease or condition	MASO	ardra	ىك لا	uton	ictim				
/Medical		resulting in death)	Due to (or as a cons								
Examiner	Sequentially list conditions, if any leading to immediate Due to (or as all insequence of):										
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687 ificate g phy as the	edic										
Box 6	M	23b. was decedent pregnant	3c. If yes, outcome pf pregn 1□Live birth 2□Feta	ancy	Tectonic	pregnanc	v			23d. Date of del	
deat deat ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🛣 No	4☐Pregnant at time of o		Other (Month	Day Year
P.O. at the de lby the stached	بار ک	9 Unknown		ulaine in Albert			on in Bort I		220 Did tol	pacco use contribute to	the cause of death?
IS, Pres that igned I be det	by	Part II. Other significant conditions cor	-	uiting in the t	indenying	cause gn	ven in Part I.		1 🗆 Y		robably 4 Unknown
Cord w require been signature	Completed	3,500 -000 011 1				-					
Aec le law has b je 2 sl	nple						-		24a. Was a autops perfori	y prior to	utopsy findings available completion of cause of
Vital Rician: The certificate his rector, page									1□ Yes	2 No 1 ☐ Yes	2 No
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Or Phys rthis ral dir	-T	1 Yes 2 No	28a. Date of Injury	ER/Outpatie		28c. Inju Wo	4 LI Nurs			ence 6 Other (Spe	city)
On O ding Pt h. After tt funeral	tion	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	М		rƙ?]Yes 2∐No	.0			
Division or Vital Records, P.O. Box 6 or attending Physician: The law requires that the death certificate death cartificate that death. Director After this certificate has been signed by the attending pair by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st fy)	treet, fact	ory, office		28f	f. Location (Si City or Town	treet and Number or Ri n, State)	ural Route Number,
Divisi To the Hospital or Atten within 24 hours after deal To the Funeral Director completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my kniner: On the basis of examinand manner stated.	owledge, dea ation and/or i	th occurrence	ed at the t	ime, date and opinion, death	l place, and h occurred	d due to the c	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
o the o the o the o the o the omple	Mec	29b. Signature and title of certifier	4		2	9c. Licen	se number	-	2	9d. Date signed (Moni	th, Day, Year)
F 3 F 8		Minn Q -8	lapiembi m	0		D.	23826	6		3-31-	DR.
4		30. Name and address of person who co	leted cause of death (Ite	m (3a) (Type	, Print)	1 1	700	U.		001	
		Glenn R. Ed	deumbe, M.	770		d Bra	anch Av	ve #B	201,	Clinton,MD	20735
Sta	te	31. Date filed (Month, Day, Year)	32. Segistrar's Sign	Di la	DEN	B					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 7,8 per fh 8878 4-25-08 yt.
State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1:36 AM BURR March 28 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bayvier Johns Hopkins If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dates f Bro 25 ar)
1 - 25 - 2008 Birthplace (State or Foreign Country) **Funeral** Months **1** M 2□ F -93--83 123-18-4381 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 1 XYes 2 □ No Director Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1038 Lerew Way Funeral 21205 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Pulling Doris Snow ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Sperscheider 1038 Lerew Way Baltimore, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills 4-1-2008 Middle River 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 hours Bowel Obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ned by the a 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Diverticulosis 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PGrunta RES-000 March 28 medical Doctor 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Baltimore Maryland 21287 Palantappan Muthappan

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) APR 0 4 2008 32. Registrar's Signature

			i icase	State of Marylar		of Health and I	-	_				
		•	for State Registrar	State of Marylar	· ·	e of Death	Reg. P	21118	10910			
1	nysiçia Medic xamine	in al	Decedent's Name (First, Middle, La	- (() ()	erson 4b. City	Town, or Location of Death	2. Date of Death	Day -2008 4c. County of Death	3. Time of Death P			
	neral ector	.00	5. Social Security Number 6. 224-32-5036 Usual Residence of Decedent	Sex 7. Age (In yrs.	last birthday) If Unde Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Yea	9. Birtho	MOTE place (State or Foreign try)			
death with the Maryland	e natified at	Director	10a. State 10b. County Md. Bal 10e. Street and Number	timore G	ity, Town or Location UYN 101. Zi	Oak o Code	10g. (Citizen of What Cour	Od. Inside City Limits 1 XYes 2 □ No ntry?			
036 urs after death wil	eny injury or other traumatic event, the Medical Examiner must be nutitled at once.	Completed by Funeral D	3410 Day To 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 M Yes 2 \(\sqrt{No}\) If Yes, Give Year or Dates:	J.S. 13. Was Dece ff Yes, spe 1 \(\subseteq Yes	2/207 dent of Hispanic Origin? (S city Cuban, Mexican, Puerl 22 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: B				
d 21215-0036 tiled within 72 hours after Hygiene.	nt, the Medical	e Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usu (Give kind of w life. DO NOT	prix done during most of works retired)	ne (First, Middle, Maid	Salto, I	Bedding			
Maryland od 2 should be filt lith and Mental Hy	traumatic eve	To Be	Earl Patt 19a. Informant's Name/Relationship MS Tors: S	erson	19b. Mailing Addres	Mar s (Street and Number or Ru	Wal Route Number, Cit	GINS Town, State, Zip	Code) 2 (207			
Baltimore, permit. Pages 1 an Depertment of Heal	injury or other		20a. Method of Disposition 1	Removal from State	Place of Disposition (Na cemetery, crematory or Disposition (Na Cemetery, crematory or Disposition (Na Cemetery, crematory or Disposition (Na Cemetery) (Na	me of other place) Cem. 4/4 nd Address of Facility	2008 C	Location - City or To	lle, Md.			
Balt Permit	eny ir		23a. Part/ Enter the disease, or cor shopy, or heart failure. List only	L. Kuss	Joseph 2222	W. North Av	e. Balto	Md. 212	Approximate			
Physical Personnel Physical Personnel Physical P	dical	cal Examiner	shopk, or heart tailwire. List on the control of th	4	quence of:	1			Interval Between Onset and Death			
I Records, P.O. Box 68 The law requires thet the death certifical	ached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Ectopic			23d. Date of deliv Month	ery Day Year			
ords, P	should be detached	۵	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause given in Part I.		co use contribute to to	he cause of death? bably 4 Sunknown			
	page 2	e Completed	25. Was case referred to medical			26. Place of De	24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available impletion of cause of			
Division of Vital Records, to attending Physician: The law requires to after death.	uneral di	To B	examiner? 1 Yes 2 2 27. Manner of Death SNatural 5 Pending investigative	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		ath Check only one Home 5 Residence 28d. Describe how in		fy)			
Division Ital or Attending	led in by the	Certification:	3 Suicide 6 Could not determine	4 Homicide determined building, etc. (Specify)								
To the Hospital of within 24 hours at To the European	oletely fil	Medical	(Check only one)	hysiciant To the best of my kn miner: On the basis of examin and manner stated.	cwisage death occure lation and/or investigatio	at the time, data and place n, in my opinion, death occ	and due to the dause urred at the time, date	and place, and due	o the cause(s)			
To the within	twoo	Ź	29b. Signature and title of certifier Ruymant Mill	v MD		D47683		Date signed (Month)	Day, Year)			
	5		30. Name and address of person who				mo 211	26				
R	Sta egistr		31. Date filed (Month, Day, Year) APR 0 4	32. Hegistrar's Sign	nature Aparla	Rushsbu.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM 26 per PHYS. 0878, 4/4/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 9:20 AM **Physician** 1,_ April 2008 Albert H. Radtke /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 □ F 198-16-8302 11/24/1923 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Harford Edgewood Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be filed within 72 hours after death with USA 78 Cattail Lane 21040 Funeral 12. Was Decedent Ever in U.S. Armed Forces? WVIII 1 X Yes 2 No WVIII If Yes, Give Korean Year or Dates: Vietnem 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16b Kind of Business/Industry
Dulaney Old Court 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Nursing Home Administration n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Hollar Charles W. Radtke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 1031 Searay Court Abingdon, MD. 21009 Charles J. Radtke/ Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 04/04/08 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of ò Parkville, MD. Parkwood Cemetery permit. Page Department of Important: If any Injury or once. 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician Due to (or as a consequence of): /Medical Examiner UZ Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signe should be d Completed by Records, 1 Tyes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2⊠ No page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Nursing Home 6 ☐ Other (Specify) Yes 2□ No 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. The Funeral Director; After the pletely filled in by the funera Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 66641 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. O. 500 upper Chesa peake Dr. Bel Air, MD 91014 Kickland 150 31. Date filed (Month, Day, Year) State APR 0 4 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 45 PM 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 24 Hrs. 8. Date of Birth (Month, Day, Year) Koad ppa If Under 24 Hrs. timore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛣 F 215-16-9508 Director Marylanc Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c, City, Town or Location 10d, Inside City Limits 10a. State 10h County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director ND Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Koac Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No 3altimore, Maryland 21215-0036 Specify: ρ Specify: 3 Widowed 4 ☐ Divorced shite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dwn Home tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot Pages 1 and 2 should be Mary abina Adam William ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Road Baltimore Joseph F 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2814 MD 2 ടാസടല 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Marylance aklawn Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services 21. Signature of Funeral Service Licensee 8800 Harford Road Parkvillemo 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARTERIOSCLEROTIC CURUNARY disease or condition resulting in death) ARTERY /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Snknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 40 Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ^OL 1 🗌 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-3-08 102/02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21236 KMALEUSIA 7602 BEVAIR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2008 Month **Physician** March 27, 3:10 AM M Mildred Florence Raftery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 27, 1922 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 85 182-14-0591 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2√ No Director MD St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20650 22680 Cedar Lane #2215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3X Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) unk and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) office work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Savot Julia French 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Lucy Timmons/daughter 41430 Breton Beach Road Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 → Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald S. Wade, Director 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ca Final disease or condition resulting in death) Physician Depsis /Medical Due to or as a consequence of): Mesentarie Cschemie **Examiner** Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATTIERO Scherate CARelo Vascular Desrase, Extension use as the burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by KENESC Failure 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has birector, page 2 s autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ After this 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Raftery Box 68760 Records, Division or Vital

within 24 hours after death To the Funeral Director: filled in by lospital or A Medical

> State Registrar

29a. Certifier

(Check only one)

31. Date filed (Month)

and address of person who completed cause of death (Item 23a) (Type, Print) W. Kurche, MD

P.O Sox 186

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

27,

mechanics wille . Me.

32. Registrar's Signature

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 1511 April 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner N/A Baltimore Baltimore Sinai Hospital 0 8. Date of Birth (Month, Day, Year) Oct 1, 1925 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Security Number **Funeral** Days No. Carolina 1 ☐ M 2 😿 F Director 220-18-5823 Usual Residence of Decedent 10d, Inside City Limits 10b County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No **Baltimore** Patient Known as Eileen Rodgers N/A Director Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 21215 3405 Grantley Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio Black Baltimore, Maryland 21215-0036 Specify þ 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Sinai Hospital College (1-4or 5+) Elementary/Secondary (0-12) Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Reid John Reid ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3405 Grantley Road Baltimore, Maryland 21215 Sheila Dorsey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State Owings Mills, Md. 04/09/08 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Si Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part . Enter the disease, of complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Respiratory
Due to (of as a consequence of): immediate Cause (Final Physician Hour disease or condition resulting in death) /Medical Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No Concer 2 No 1 TYes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Sinai Hospital of Baltimore Brandon MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 04 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Patricia Ruby 2008 OAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore dale Husnita If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex **Funeral** Min. 9/12/1951 Months Hours Maryland 1 □ M 2 🗙 F 56 154-44-7663 KWOY, Patricia Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at Baltimore 1 XYes 2 No MD N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 3728 Echodale Ave. items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2√2 No Specify White 3 □ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Towson University Administrator is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event Be Mary Brough Michael Patrick Beere ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3728 Echodale Ave. Baltimore, Maryland 21206 Thomas Ruby / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hillton Serv. Corp. 4/7/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, 21. Signature of Funeral Service 21204 Maryland Ruck Towson Funeral Homé, 1050 York Road Inc. 23a. Part1. Enter the disease, or complications that cause dube death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Que fr (or as a consequence of): Examiner utropenio Sequentially list conditions, from the doing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a contequence of g physician and as the burial-transit death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an autopsy performen?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has certificate Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 🔲 Yes **Inpatient** 2 ER/Outpatient 3 DOA this 27. Manher of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Attending 1 Natural 5 Pending Injury Jospitar C. 4 hours after dea.

-ral Director: After the fire the 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral of completely filled is Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number CM BOAILIERY 3/30/08. D0064755

State Registrar

31. Date filed

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Drive Balto MD 21237

address of person who completed cause of death (Item 23a) (Type, Print)

les

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month TEROME STEWART Mare 2008 10:15 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balt, more Cit entalou Baltimore Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9 Birtholace (State or oreign **Funeral** Country Months Days Hours Min 217-40-6432 Director 01 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bentalou 929 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Tes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kailroad Brakeman th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Sommerville lames ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 5012 Ave. Balto Md. Z1229 admondson Hltved 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State Serverna Park -4-08 4 ☐ Donation 5 ☐ Other (Specify) arpenters 21. Signature of Funeral Service Licenses Funeral Services Balto MD. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cel Squamous (ance netasta morths /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,%Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes W No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certific 29d, Date signed (Month, Day, Year) Name and address of person who complete cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

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	h the Mar or 28a-f sl e notified	Irector	MD Montgomery Gaithersburg 106. Street and Number 107. Zip Code						1 ☐ Yes 2√ No 10g. Citizen of What Country?			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Exactivat must be profilled at	by Funeral Director	10006 Stedwick	12. Was Decedent Armed Forces?	No	20 Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	0886 spanic Origin? (Spen, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, Specify: bla	etc.		
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	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic 900.		19a. Informant's Name/Relationship (Type, Print) Althea Woodland Nursing Home 1000 Daleview Drive Silver Spring, MD 20901 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 YOthen (Specify) in state 21. Signature of Fineral Silves Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201									
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P.O. Box 6	death certif e attending id for use as	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown						23d. Date of delivery Month Day Year			
	requires that the signed thould be de	Completed by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the ur	nderlying cause give	n in Part I.	1 ☐ Yes	24b. Were auto	ably 4 [Unknown		
ital Re		0	25. Was case referred to medical				26. Place of Death	autopsy performed 1 Yes 2 (Check only one)	death?	npletion of cause of		
Division of Vital Records,	inding Physath. ir: After this	Certification; To B	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resident							ence 6 Other (Specify) ow injury occurred itreet and Number or Rural Route Number,		
Ο̈́	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Homicide 4 Homicide 4 Homicide 5 Homicide 5 Homicide 6 Homicide 6 Homicide 6 Homicide 7 Homicide 6 Homicide 7 Homicide 8 Homicide 1 Homicide 2 Homi									
	thin 24 his the Fun thin pletely	Medical	(Check only one) 2 Medical Ex	aminer: On the basis o and manner st	f examination and/or invated.	vestigation, in my op	inion, death occurre	ed at the time, date	and place, and due to Date signed (Month,	the cause(s)		
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			30. Name and address of person wh	K Affin	eath (Item 23a) (Type,	Print) 831 Silvers	pring	mo 120:	3-16- BLVD E	ast		
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1. Decedent's Name (First, Middle, Last) 2. Date of Death

Month 3. Time of Death SPURRIER ANN SHIRLE 5:10 PM pril 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROLL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days Hours 1 □ M 2 🕅 F Yrs. 213-46-4154 60 MAY 28,1947 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt; If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dicai Examiner must be notifled at MD 1 ☐ Yes 2 No CARROLL WESTMINSTER Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 OLD TANEYTOWN RD. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 DESIGN EMBROIDER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JAMES** BOWERS ELSIE CRAMBLITT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE ALBRIGHT -DAUGHTER 3794 BALTIMORE PIKE, HANOVER, PA 17331 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State permit. Page Department of Important; If any Injury or once, 4 Donation 5 Dother (Specify) ALL COUNTY CREMATION 4/5/08 SYKESVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complication. If at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 DEctopic pregnancy Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>P</u> 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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D0017695 AP212 1, 2008 29b. Signature and title of certifier elon, M.D CAPROLL HOSPITAL CENTER, WESTMINSTER, MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELCU, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Betty B. Sullivan MARCH 31, 3:43 P^M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) Dec. 10, 1916 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F Months Hours Min. 294-07-3543 91 Ohio Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. i marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐Yes 2 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 Roundwood Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: þ 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education ulth and Mental Hve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Esther Coyne Phillip Brennan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bailey / daughter 1000 Cold Bottom Road; Sparks, MD 21152 20a. Method of Disposition 1 ☑ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dulaney Valley Mem Gardens 4/4/08 Timonium, MD 21. Signature of F n service is ep e 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MPSF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 250 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3 □ DOA 2 1 Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box $68760, \mathscr{C}_{\mathscr{L}}$ To the Hospital or Attending Physiclan:

Baltimore, Maryland 21215-0036

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DHMH 17 Rev 1/2001

State Registrar

and manner stated.

D0061515

29c. License number

29d. Date signed (Month, Day, Year) ωŽ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. CHAPLE ST BALTIMORE, 618mg Registrar's Signature

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 878 4-4-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death L^{Day} 2008^{Year} **Physician** APR'IL 10:28P M **GLASS** SODARO 1 MILDRED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth (Month, Day, 1916) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**Y**☐ F 213-05-4834 91 MD Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiens in attuing a lier pearn With the Maryla Department of Health and Mental Hygiens I important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational by notified at once. 1 Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE, APT. 410 21208 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No Specify: Specify: δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGED REAL ESTATE PROPERTY REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS BRITT ANNA UNOBTAINABLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2017 BURDOCK ROAD, PIKESVILLE, MD 21208 DEBBI KLEIMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH TFILOH CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/03/2008 BALTIMORE, MD 4☐Denation 5 ☐Other (Specify) Signature of Funeral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 omes Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yens **Physician** /Medical Due to (or as a consequence of): erebormenter Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 to Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □Yes 2 2 No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Wispice 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 [] Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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			1 - For State Registrar		,		rtificat				· · · · · ·	Reg. No	-	000	1.0	000
1		-	Decedent's Name (First, Middle	e, Last)					-		2. Date of D	eath	6=	UUO	3. Time of	Death
	Physicia /Medic		Michele E. Smith								Month 03	25)	2008	1:30	РМ
	Examin		4a. Facility Name (If not institution, give street and number) 708 Glen Allen Drive 4b. City, Town, or Location of De Baltimore							9		4c. County of Death				
	Funeral Director		5. Social Security Number 217–56–3812	6. Sex 1 ☐ M 2 🕱 I		rs. last birthday) 5 Yrs.	Months Days Hours Min			8. Date of Birth (Month, Day, Year) 10/12/1952			Birthplace (State or Foreign Country) NY		or Foreign	
	land ow It		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li											ity Limits		
	a-f sh	ctor	MD Baltimore 1xXYes 2										2 🗆 No			
	ith the	Director	10e. Street and Number			-	10f. Zip					10g. Cit	izen o	f What Cour	try?	
	sath w s 23a nust b	ral	708 Glen Allen Dri	11.0	21229						14 D	USA	!!!			
	ter de iner n	Funeral	11. Marital Status 1				If Yes, specify Cuban', Mexican, Puèrto Rican, etc.)						BI	ace - Americ lack, White,	etc.	
	ours ar	by		If Yes, Give 1 ☐ Yes 2 ☐ No Specify:									Spec	oify.Africa	an Amer	ican
	72 hc "natur dical	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							ing	16b. K	ind of	Business/Ind	dustry		
4	within ene. than '	Completed	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+) 5 +	- life.	accountant						TTN	MBC		
2	il Hygi other ent, tl	Be Co	17. Father's Name (First, Middle,	Last)						er's Name	e (First, Middle	st, Middle, Maiden Surname)				
	ould be Menta arked atic ev	To B	Bernard Carter								Posey (Griffin				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Horace R. Smith / 1			Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Allen Drive; Baltimore, MD 21229										
5	ges 1 at 1 of He If item		20a. Method of Disposition 1	3 □Removal fro		. Place of Dispo cemetery, cre	osition (Nar matory or o	ne of ther place	₽)	1	Date	20c. Lo	ocation	a - City or To	wn, State	
	t. Pag ntment rtant: njury		4 Donation 5 Other (Specify) Arbuts Memorial Park 03/31/2008 Baltimore, Maryland													
3	Depar Depar Impor any ir once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road; Randallstown, Maryland 21133													
3	1 to 1 to		23a. Part1. Enter the disease, or	complications the	at caused the de								ryla	and 211	Approximat	e
L,	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause o	on each line.			0							Interval Bet Onset and I	ween Death
	/Medical		disease or condition resulting in death)	a. Due	to (or as a cons	PASTAR equence of):	-	ANC	LEATI	<u>_</u>	CANCE	n				
Į.	Examiner	_	Sequentially list conditions.	b												
٦	st x/ E	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
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	ath ce ttendii or use	ian/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of delivery Month Day Year					
5	he de	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)								— Jay			Day	i eai	
	s that the ned by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did							tobacco use contribute to the cause of death?						
3	equires	ed by							1 🗆	☐ Yes 2☐ No 3☐ Probably 4☐ Unknown				Jnknown		
)	law re as bee 2 sho	Completed									24a. Wa	s an opsy	24b	. Were auto	psy findings	available
	The cate h	E O									per 1□ Yes	formed?		death?		ause oi
	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Deatl	n (Check only	one)				
5	Phys r this eral dii	<u>유</u>	1 Yes 2 No 27. Manner of Death		☐ Inpatient 2 ate of Injury	☐ ER/Outpatier 28b. Time o		'A	4 LI Nu		me 5 Res				/)	
	nding ath. r: Afte e fune	ation	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig		fonth, Day Year)	Injury	м	l8c. Injury Work 1 ⊟ Y	? ′es 2 🗆		28d. Describe how injury occurred					
	or Atte after des Directo in by th	Certification:	3 Suicide 6 Could not be						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
:	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death after this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										3)			
1	To th Withir To th comp	Me	29b. Signature and title of certifier		29c. License number					29d. Date signed (Month, Day, Year)						
			Nort 18		MD D0066107				4/3/2008 CENTER BALAMONE, 1. MO 21201							
	10		30. Name and address of person	who completed c	ause of death (It	em 23a) (Type,	Print) G	RISEN	EBAW	m G	NCER	CENT	EN	B	nomo	NE,
45	, Sta	to	31. Date filed (Month. Dav. Year)	A MO	2. Registrar's Sig	nature		22 5	5. G.	NEEN	E 25				MO 2	21201
	Registra		31. Date filed (Month, Day, Year) APR 0 4 2	008	de B	A Same	R.									

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph Denton Thompson, III 28, 2008 5:35 P. March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Owings Mills Baltimore County 11425 Garrison Forest Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | July 14,1952 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 142 M 2□F 55 216-56-5233 Baltimore, MD. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han activated. 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Owings Mills 1 ☐ Yes 2 No Maryland Baltimore County Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 United States 11425 Garrison Forest Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/a Elementary/Secondary (0-12) Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Denton Thompson, Jr. Thelma Marie Bull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6446 Cloister Gate Drive Sherri Ann Thompson (Sister) Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 04, 1 ☐ Burial 24 Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gair) Panagand Addition Timonium, Maryland 21093. P.A. 2325 York Road Timonium, Maryland 21093. 21. Signature of Funeral Service License Jeffrey L. 23a. 611. In or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in item. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ACUTE Myocarpial MO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and burlal-trans requires that the death certificate be execut Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2€No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐ Yes 2 7 No or Attending Physiclan: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) BY No Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After (Month, Day Year) latural 5 Pending investigation neral Director: A filled in by the ft 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discription Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

To the Hospital

Registrar DHMH 17 Rev 1/2001

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State

29b. Signature

Michael Suter, M.D.

31. Date filed (Month, Day, Year)

8109 Harford Road

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Parkville, Maryland

29d. Date signed (Month, Day, Year)

21234

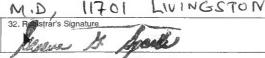
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31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MARCH

ROAD

SUITE #101, FORT

WASKINGTON, WI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Rosalie Marie Terminella 2008 /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and 4b. City. Fown, or Location of Death HIMON In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F 83 06-09-1924 Director 219-18-8980 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No or items 23a or 28a-f shaminer must be notified Funeral Director Maryland| Harford Abingdon 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1326 Hidden Stream Drive U.S.A. 21009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-6036 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Checking Account Adjuster Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ot ပ Frank V. Barbagallo Venera A. Mandella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Venera A. Amati (Daughter) 1326 Hidden Stream Drive Abingdon, MD 21009 27 Injury or other Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cem. 04-02-2008 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signatore of Funeral Service Licensee Depenie Inc. 610 W. MacPhail Rd Bel Air, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pevere disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner rneumonia Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cavitary burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 900 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 DANo monaru 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 228155 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Yark Hang tranklin uare

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 04

2008

ORIGINAL

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** GEORGE TERRY /Medical March 28, 2008 11:00 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Multimedical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1☐M 2☐F Days Yrs. Director 136-07-2857 94 11-18-1913 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. In the Maryland Hyglene wit: if item 27 is marked other than "natural", or items 23a or 28a-1 show any or other traumatic avant. The Medical Evantiment has indifficibled. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Director Baltimore Marvland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7923 Eastdale Road 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ White 3 X Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Millwright Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bertie Mildred Mooneyham ပ George Washington Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Glenn P. Evans</u> 3 Elinor Avenue Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 4/3/2008 Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Was 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy igned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No Division of Vital 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death, To the Funeral Director: After Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q, RD SUITE 110 SANTIA 00 64MA SHAKUNMALA 31. Date filed (Mont Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 20ඊ්ඩ් Thomas 6:05 a M Marv Κ. April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March | March 9. Birthplace (State or Foreign Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 214-22-6529 94 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, it. A Hydical Exprint mutal to mitting at any or other traumatic event, it. A Hydical Exprint. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 6610 Mover Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White Completed by 1 ☐Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Conits Constatine Konstant ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 Moyer Ave. Baltimore, Md. 21206 Mr. Paul P. Thomas/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. 4-4-08 Woodlawn, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License <u>1050 York Rd. Towson, Md.</u> 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ icate has been si 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an After this certificate 2 No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊡No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) APR 0 4 2008



N.C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

It balto MI 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1340 A 2008 Nancy В. Vance 61 /Medical 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Square Hospital enter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/28/1949 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 ▼ F Director 212–56–6156 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Maryland Baltimore Nottingham 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 Aspen Mill Road 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 XX Never Married 2 ☐ Married 2**/XX**00 Maryland 2/215-0036 1 ☐ Yes 2XXXNo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Federal Court Is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Marvin H. Vance Mildred R. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 Woodlyn Road, Baltimore, Maryland 21221 Mildred R. Vance (Mother) Vance Baltimore, ¶ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 04/05/2008 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Eugen Scholes Picerises 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. <u>1407 Old Eastern Avenue, Essex, Mary</u>land 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, physician a s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. the a 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed? Yes 2 No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Y No 2 ER/Outpatient 3 DOA Certification: To funeral 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural (Month, Day Year) hours after death.
uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10 State

> Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person

pleted cause of death (Item 23a) (Type, Print)

9000 Franklin

1.02 Registrar's Sig

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** John William Wilson 12:00 A March 31, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arden Court Assisted Living Towson Baltimore 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**⊠**M 2□F Months Hours Director 5, 1921 218-14-5480 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Glen Arm 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 11630 Glen Arm Road Apt. 215 21057 Funerai , or Items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐XYes 2 f Yes, Give 2 No 1 ☐ Yes 2 ☑ No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Owner / Operator Retail Complex filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be George D. Wilson Lucy H. Schuster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i Health 11630 Glen Arm Road, Glen Arm, MD 21057 Clara R. Wilson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ₽ 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 4-3-08 ò Department o Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Street, Maryland Highland Presbyterian Cem. 22. Name and didress of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1(uss 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Merioscheratic Physician ardiovascula years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner sician and burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 C Other (specify) ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No ပ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Natural 2 Accident death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D 25643 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FaulknermD/6565N. Charles Steat Suite 209

31. Date filed (Month, Day, Year) State APR 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryland		tificate of D		, 0	ene g. No.2008	10930				
	siciar	Decedent's Name (First, Middle, Last) Donnie Watson					pr 1, 2008 Year	3. Time of Death 10:15 a _M				
	edica mine	4a. Facility Name (If not institution, give street and number)	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death									
Fune Direct		4002 Cottage Avenue 5. Social Security Number 217-30-5390 6. Sex 1 □ M 2 □ F 71	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 17,	9. Birthr 1937 No	olace (State or Foreign October Carolina				
e Maryland a-f show tified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, T Maryland N/A	Town or Loc		timore			l0d. Inside City Limits 1 Yes 2 No				
with the 3a or 28		10e. Street and Number 4002 Cottage Avenue		10f. Zip Code	21215	10	g. Citizen of What Cou U.S.	,				
ING Z1Z13-UU35 be filed within 72 hours after death with the Maryland tal Hygiene. and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	200	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Uss Decedent of Hisp f Yes, specify Cuban, □ Yes 2☐ X No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:					
vithin 72 ho within 72 ho iene. than "natu the Medical	Total and C	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give I life. D	ent's Usual Occupati kind of work done dur OO NOT use retired) Products	on ring most of worki Supervisor	ing Plant						
		17. Father's Name (First, Middle, Last)	1	18. Mother's Name (First, Middle, Maiden Surname) Lillian Marie Watson								
Maryl nd 2 shoul tith and Me 27 is mark	F			e Number, City or Town, State, Zip Code) Maryland 21215								
Page Page ment c ant: If		4 Donation 5 Other (Specify)		sition (Name of natory or other place) o Crematory, I	1	04/03/08	Oc. Location - City or To Catonsville,					
permit. Departi	ouce	21. Signor of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217										
Physicia	_	23a. Parf 1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	onot ente		such as cardiac c		st,	Approximate Interval Between Onset and Death				
/Medic Examine		Due to (or as a consequence of):										
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To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director,	Certification.	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
ne Hospi n 24 hou ne Funer Metely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the within To the comp	M	29b. Signature and title of certifier	'n	29c. License n	umber	290	d. Date signed (Month,					
9		30. Name and address of person who completed cause of death (Item 23	Ba) (Type, F	erint) Bens	amin	victor sville	MC 21	12008				
	State strar	TOP O A 7000 St. St.		(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	1 (~)	SVIIIC	11101 21	200				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day 4/ma 08 30 /Medical 4a. Facility Name (If not institution, 4c. County of Death 4b. City, Town, or Location of Death Examiner NA Baltimore Levindale (renatric If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 28-027 1 □ M 2 🗷 Director Usual Residence of Decedent Pages 1 and 2 sho lid be filed within 72 hours after death with the Maryland nent of Health and Nental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits then "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 1 Nes 2 No MD Directo NA Ba TIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? US H 2121 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 3 Widowed 4 □ Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Sow. Gervicos Ker h and it ental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ orse Sadie NUrca 19a. Informant's Name/Relationship (Type. Print) 195. Elizabeth Saverge Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is Stone wood 21239 Daug MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arbotus 4/08 Men. rbutus 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Fune al Service License Loseph W atelle North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis Neck /Medical Due to (or as a consequence of) Examiner Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, and Due to (or as a consequence of) attending physician a for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 40 9□Unknown 9 I Unknown þ signed I Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2500 within 24 hours after deam.

To the Funeral Director. After this certificate I commletely filled in by the funeral director, pag 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 🗌 Yes 2 No 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death account of the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

20

_oState Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NEJIM ALKHATIB 750AM MAR 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 ★M 2 ☐ F 451-47-8748 Director 11/22/1959 Iraq Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10h County 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at Md. Frederick 1 N Yes 2 No Director New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10091 Sparrow Court 21774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Heath and Mental Hygiene.
Item 271s marked outber than "natural", or itee other traumatic event, the Medical Examines. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Nejim Alkhatib's Elementary/Secondary (0-12) College (1-4or 5+) Architect Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 is marked ot any injury or other traumatic evel Abdul Ghayoor Alkhatib Inam Munir ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Tisseaux/Wife 10091 Sparrow Court New Market, Md. 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 3/19/08 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign nurs of Funeral Sev 22. Name and Address of Facility Universal Mortuary ce Licens LOC 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PAPILLARY 4 /2 YRS **Physician** CELL CANCER resulting in death) /Medical Due to (or as a consquence of): Examiner Sequentially list conditions, if a year and in the inner distribution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2XNo 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 **X**No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director After 1 Natural 2 ☐ Accident 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and tigle of ceptifie 29d. Date signed (Month, Day, Year) D0061083 MARCH 18,2008 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CTR. DR. #300, ROCKVILLE, MD 20850 9707 32. Refistrar's Signature State Registrar

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		For State Registrar			or room y room		rtificate of	lealth an Death		Reg. No.	200	0 1000
		Hegistrar Decedent's Nam	e (First, Mida	le, Last)		001	tineate or	Douin	2. Date of D	eath	200	3. Time of Death
Physici /Medi		Donal	Lđ		Andre	ews			03	Day 13	Year 08	1043
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erican		WMHS-Mer		Campus 6. Sex	7. Age (In yrs. I	est hirthday)	Cumber		Hrs. 8. Date of B		11egan	
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ent ent rt: II		20a. Method of Dis 1 ☐ Xiurial 2 4 ☐ Donation	Cremation	3 ☐Removal from			sition (Name of matory or other place Demetery	ce)	Date 3/17/2008		ition - City or Imberla	Town, State and MD
permit. P Departm Importar any Injur		21. Signature of Fi	neral S-rice	cedsee -		22	2. Name and Addre Scarpe 108 Vi		l Home, PA nue: Cumber	land. MD	21502	
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or Attending Physician: ifter death. Director: After this certifica in by the funeral director, p	edical Certification: To Be Completed by	23b. Was deceden in the past 12 1	rred to madical formation investing the condition of the	I Live 4 Preg 9 Unki I Hospital: 1 28a. Date (Mor gation not be nined 28e. Plac built and Physician: To the Examiner: On the and mail	inant at time of denown Jeath but not resurble to finjury of Injury of Injury - At hooling, etc. (Specify e best of my known basis of examinatiner stated.	ery/Outpatien 28b. Time of Injury me, farm, stre	Other (specify) t 3 DOA Other 28c. Injur Wor M 1 Deet, factory, office	26. Place of er: 4 ☐ Nursir y at k? Yes 2 ☐ No	24a. Wa auture per 1 Yes Death Check onling Home 5 Res 28d. Describe 28f. Location City or Tolloce, and due to the occurred at the time	tobacco use Yes 2 s an opsy formed? 2 No one sidence 6 how injury of (Street and I own, State) e cause(s) ar o, date and p	Month ' contribute to a prior to death? 1 Yes Occurred Number or R Indiananer adace, and du	Day Year o the cause of death? robably 4 □Unknov utopsy findings availat completion of cause o s 2 □ No ural Route Number,

State of Maryland / Department of Health and Mental Hygien@ [] [] [] 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 3:45AM Vincent Abrams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Coffman Nursing Home Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (Statements) 1920 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1∭ M 2□ F Months Days Yrs. 87 Director 068-16-7688 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Itam 27 is marked other then "natural", or Iteme 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18826 Briarwood Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Iten Important: or other traumatic event, the Medical Eventinat ORE. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Metalurgist Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Hillside Ave., West Haven, CT Phyllis Kidd/Personal Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | 4/1/2008 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and tor use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the a 9☐ Unknown 9 Unknown ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available pror to completion of cause of death? 24a. Was an autopsy performed? 2010 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to examiner? 26. Place of De Check only one Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending within 24 hours after death.

To the Funeral Director: All completely tilled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 31. Date filled (Month, Day, Year) State Registrar

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

Ce	rtifica	ite	of	Dea	th

Reg. No. 2008

		Mr 14-00	_	· ·	\$ "w" w"
2. Date of Death					3. Time of Deat
Month	Day		Y	ear	12115
3 /	2	22	00	8	1400
	4c.	Cour	nty of	Death	

4b. City, Town, or Location of Death NUISINS CANTER 7. Age (In yrs. last birthday) 67

NNAPOLIS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

MUNDEL Birthplace (State or Foreign Country) July 16, 1940 Washington, DC

10c. City, Town or Location

Annapolis

10d. Inside City Limits 1√∑Yes 2 No

10f. Zip Code 10g. Citizen of What Country?

18. Mother's Name (First, Middle, Maiden Surname)

900 Van Buren Street

12. Was Decedent Ever in U.S. Armed Forces?

21403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🙀 No Specify:

United States 14. Race - American Indian, Black, White, etc.

Black

1 ☑ Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

1 Yes 2 No If Yes, Give Year or Dates:

16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16h Kind of Business/Industry

Specify:

Elementary/Secondary (0-12)

2 College (1-4or 5+)

Military

Government

17. Father's Name (First, Middle, Last)

Isabelle Cary

Frank Barnes 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Eugene Barnes - Brother

7405 Forests Edge Court Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date

20a. Method of Disposition

1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Maryland Vet's Cemetery Mar 19, 2008 Cheltenham, MD 22. Name and Address of Facility Stewart Funeral Home, Inc.

21. Signature of Funeral Service License

23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line.

Immediate Callie (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

4001 Benning Road, NE Washington, DC 20019

3altimore, Maryland 21215-0036

Physician /Medical

Examiner

burial-trar

attending physician for use as the buria

been signed by the should be detached

funeral director, page 2 s

filled in by

this

After t

24 hours a

within 2

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Due to (or as a consequence of) ALCOHOLIC

Due to (or as a consequence of,

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23d Date of delivery Month

23b. Was decedent pregnant in the past 12 months? 9 Unknown

IF FEMALE:

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 I Inknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

WASHINSTON D.C.

1 Yes 2 No 3 Probably ≉ Onknown 24a Was an

DIASTICS MELLINUS

autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 1 Watural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be

Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier

00026624

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1160 UNENUM ESTEN 14653

State Registrar 31. Date filed (Month, Day, Year) 9 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 13, **Physician** 2008 7:30 py ANNIE BRIGHT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE's BRADFORD OAKS NURSING HOME CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/5/1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 SyF 578-54-5372 65 Director WASH, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 Yes 2 No Director PRINCE GEORGE'S MD UPPER MARLBORO 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 12638 DARLENEN STREET 20774 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.

other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3 Widowed 4 Divorced African -American ind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MARKETING SPECIALIST GOVERNMENT year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I JAMES HAYNESWORTH LILLIE BOYKIN ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I JOSHUA BRIGHT/HUSBAND 12638 DARLENEN ST, UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) △ 03/21/2008 LANDOVER, MD HARMONY 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Sign neral Service 7474 LANDOVER ROAD, LANDOVER, MD20785 23a. 1 nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that the death certificate be executed that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes No No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 X Nursing Home 1 ☐ Yes 2X No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury after death.

Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a tv Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D35206 MARCH 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM T. TANNER, M.D. 11701 LIVINGSTON ROAD, FORT WASHINGTON, MD 20744 31. Date filed (Month, Day, MAR 1 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** OPHELIA W. BLACK MARCH 2008 7:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 805 ST. JAMES COURT PRINCE GEORGES ACCOKEEK If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2**X** F Director 63 02/22/1945 NORTH CAROLINA 244-70-6326 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f shov ner must be notified at MD PRINCE GEORGES 1 X Yes 2 □ No ACCOKEEK Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 805 ST. JAMES COURT 20607 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZXNo If Yes, Give Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 YEARS **TEACHER** PRIVATE l 2 should be filed w h and Mental Hygiel 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLIE GUINE SARAH DILLARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau RAULPHARD BLACK/HUSBAND 805 ST. JAMES COURT ACCOKEEK, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LAKEMONT CEMETERY 03/15/2008 DAVIDSONVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-tran Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 5 performed certificate 1∐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Tes ပ္ XXNo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ∏ No 2 Accident 6 ☐ Could not be

P.0. Division or Vital Records.

I Director: After t d in by the funera or Attending death. filled in by within 24 hours after To the Hospital To the Funeral

Medical 118

R 1 9 2008 MAR 1 9

29b. Signature and title of certifie

3 Suicide

29a. Certifier

4 ☐ Homicide

VERED STEARNS 1650 ORLEANS STREET CRB-1 BALTIMORE, MD 21231 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Registrar

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

D0059325

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARCH 18, 2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

0530

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 X Yes 2 No

Approximate Interval Between Onset and Death

Pennsylvania

Black, White, etc.

(Rugg) Bruner

Specify: White

Month

Cumberland, MD. 21502

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

DHMH 17 Rev 1/2001

nde

State

Registrar

lerri

31. Date filed (Month, Day, Year)

MAR 2 0 2008

500 Memoria

7.0

gistrar's Signature

			State of Maryland / Dep		-	•			
			_ FOI	rtificate of Death		g. No. 900	0 10000		
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al	Madelyn Anne Ball	Late City Transport Death	March	06, 200			
}	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Rockville		4c. County of Deat			
****	Funeral		Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birth Day, Year) 9. Birthplace (State or Foreign Country)			
	Director		None 1□M 2⊠F 0 Yrs.	Months Days Hours Min. 54	(Month, Day, March 6,		aryland		
	w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits		
	Maryla f sho led at	ō		castle			1 ☐ Yes 2 🖾 No		
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?		
	uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notifled at	al D	442 Moss Spring Avenue	17225		United St	ates		
	r dea	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
36	s afte	by Fi	1 Tx Never Married 2 Married 1 Yes 2 Tx No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ② No Specify:		Specify:	White		
8	thour attural cal Ex	edk	15 Decedent's Education 16a, Dec	edent's Usual Occupation	1	6b. Kind of Business	White Industry		
2	hin 7%	plet	(Specify only highest grade completed) (Giv life. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	king				
7	ed wit ygien ygien ter th	Completed	0	None		None			
gu	be fill H	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M.				
Maryland 21215-0036	hould d Mer marke matic	မ	Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mai	Christ ling Address (Street and Number or Rui			Zin Cade)		
	nd 2 s Ilth an 27 is i		1	loss Spring Avenue					
ē,	s 1 ar if Hea item 3		20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or			
E	Page nent c int: If	r		oln Crematory 3/20	/2008 B	rentwood,	MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Egneral Service Licensee	22. Name and Address of Facility Si	mple Trib	oute			
	#0 = # 9			040 Rockville Pike					
			23a. Part1. Enter the direction of the second complications that caused the death. Do not enshook, or heart follow. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death		
Î	Physician /Medical	Z h	Immediate Oduse (Finat disease or condition resulting in death) a. fetal hydroresulting in death)	۶ م			2		
A	Examiner		Due to (or as a consequence of):						
4		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.						
,00	te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):						
687	eath certificate be executed attending physician and for use as the burial-transit	dical	d						
×	The law requires that the death certifica ate has been signed by the attending phrage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	livery		
. Box	death e atter	icia	in the past 12 months? 1 Ves 2 M No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
P. O.	at the by th tache	hys	9 ☐ Unknown N						
S,	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to s 2 No 3 □ Pi	o the cause of death? robably 4 □Unknown		
Records,	requ	Completed							
æ	he lav e has ge 2 s	mp			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of		
Vital			25. Was case referred to medical	26 Place of Deep	th (Check only one	□ No 1 □ Yes	2 2 N o		
	Physician: The la rithis certificate has ral director, page 2	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		nce 6 Other (Spe	cify)		
0	Attending Physician: r death. ector: After this certifica by the funeral director. I		27. Manner of Death 1		28d. Describe how	v injury occurred			
Sio	tendi eath. tor: A the fu	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No					
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	теет, тастогу, опісе	28t. Location (Stre	eet and Number or Ri State)	ural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	, and due to the car	use(s) and manner as	s stated.		
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)		
	Vithi To t	Ň	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	th, Day, Year)		
	1		y G Lot	51461		5/7/0	8		
			30. Name and address of person who completed cause of death (Item 23a) (Type JAMES ROST, 990/ MEDICAL	CENTER DRIVE, F	Rockins	= MADOIL	AUD PAREN		
	Sta	te	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	CENTER DRIVE, I	WILL WILL	C, IVITINGL	AND SUBSO		
	Registr	ar	MAR 2 0 2008 Sieve 15 1	parti					

Amend 20b, 3/22/08, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per FD, CCHD, drw State of Maryland / Department of Health and Mental Hygiene 3/20/08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marv Bernice Brooks 5:40 A M March 18. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 2420 Sixes Road Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | 5. Social Security Number 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) **Funeral** 1 M 2 JxF 214-34-4894 85 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f sho 1 □Yes 2 N No Director Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 2420 Sixes Road 20678 USA filed within 72 hours after death v Hygiene." Ither than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2/OXNo Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John 01iver Freeland Lillian Plater ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth J. Harrod/daughter P.O. Box 558 Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3/22 to 2008 ty☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooks UMC Cem. St. Leonard, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE Teas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Que to (or as a consequence of) at any, leading to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending I IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARCINOMA 0 = RIGHT BREAST 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 100 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Vivatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3 - 20 - 2008 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

NUAR MUNSKI MD 100 HOS HOSP RD. PRINCE FREDERICK MD 20678 10

State

Registrar DHMH 17 Rev 1/2001

			State of Maryland / Departme State of Maryland / Departme Amend Item 25 per dr., g878,04/1/2	nt of Health an 4/08dhb ate of Death	d Mental Hygie Reg	ene 2008 1094
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		Mamie Malinda Blake		March	22,2008 01/3 M
j	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. Cit	ty, Town, or Location of D	eath	4c. County of Death
	<i>y</i>		Memorial Hospital	taston		Talbot
	Funeral		1 M 2 F V Month	ler 1 Year If Under 24 s Days Hours N	Min. (Month, Day,)	
i in	Director		215-20-0802 1		November	ll 1924 Virginia
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary Fied	호	Maryland Caroline Denton			1 ☐Yes 2 ☐ No
	r 28a	Director		Zip Code	100	g. Citizen of What Country?
	h with	교	1518 Cattail Commons Way	21629	Ur	nited States of Americ
	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec Armed Forces? 13. Was Dec	cedent of Hispanic Origin' pecify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
ထွ	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes	2⊠ No Specify:	derio Filodii, etc.)	
2-0036	ours ural", I Exa	d by	3 ½ Widowed 4 □ Divorced Year or Dates:			Specify: Black
N N	"nati	Completed	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of the DONOT)	sual Occupation work done during most of use retired)	working	b. Kind of Business/Industry
2	withir ene. than ne Me	m d	Elementary/Secondary (0-12) College (1-4or 5+)	ndress		Laundry
0 0	filed Hygi ther		8 Laur 17. Father's Name (<i>First, Middle, Last</i>)		Name (First, Middle, Ma	
an	d be ental ced o	To Be	William Medford Simmons	Í	.lda Virgini	•
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Items 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-				City or Town, State, Zip Code)
	and 2 ealth a n 27 is ier trau		Veronica Garcia Daughter 1518 Cat	tail Commons	Way, Dento	on, Maryland 21629
altimore,	es 1 a of Hea fitem rothe	1 3	20a. Method of Disposition (No. 20b. Place of Disposition (No.			Oc. Location - City or Town, State
Ĕ	Pages nent of int; If it		1 □ Reurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Richards Memo	1	3/29/2008 H	Easton, Maryland
a	permit. Pages Department of Important: If il any Injury or once.		21 Six Sure of Funeral Service Licensee 22 Name	and Address of Facility Funeral Hom		, ,
<u>m</u>	8 9 7 8 8	N 3	Tand put 1 100 12 Sor	runeral non uth Second S	ie, r.a. Street. Dent	on, Maryland 21629
H			23a. Part1. Enter the disease of complications that caused the death. Do not enter the m shock, or heart failure. Eist only one cause on each line.	ode of dying, such as car	diac or respiratory arres	t, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	in the	et dese	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequenty of):	R. I.A.	n	
16	LAGIIIIICI	_	Sequentially list conditions, b.	Deebe	wa	
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): c. Lharl Warls	the C). ().	4
_ =	and al-trar	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):	melye 1	Milmoney	usess
8760	ficate be executed physician and s the burial-transit	dical E				
9	tificati g phy as the	ledic				
ROX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic			23d. Date of delivery
	deat le atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Month Day Year
J O	at the de by the	hy	3 🗆 OUKNOWN			
	w requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.		cco use contribute to the cause of death?
0	requii	ted			1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Records,	law has b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u></u>		S			performe 1□ Yes 2□	ed? death? ▼No 1 ☐ Yes 2 ☐ No
Ž	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	Other	Death Check onl one	
ō	5 5 5	2	1 ☐ Yes 2 ☐ No ☐ TOSPITEL! 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ I 27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursir	g Home 5 Residen	ce 6 Other (Specify)
	ding h. After fune	tio	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred
DIVISION	deat deat ctor: y the	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factor		28f. Location (Stre	et and Number or Rural Route Number.
\leq	al or Attending P. after death. I Director: After t d in by the funera	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigati	ed at the time, date and p	lace, and due to the cau	se(s) and manner as stated.
	the H nin 24 the F nplete	Medical	and manner stated.			
	5 *** 5 000	2	29b. Signature and, title of certifier	9c. License number	290	Date signed (Month, Day, Year)
			Myhhlu) "D	D 0 3 3	7	3/25/08
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 STREET	, CAMBRI	DGF, MD-21613
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- I FEL I	3 911 1104	245/100
	Registr		MAR 2 6 2008	e		

			For State Registrar	State of Ma	aryiand		rtificate of		d Mental H	ygien Reg. N	/11111	109	942
Dh	voici		1. Decedent's Name (First, Middle, Las	st)					2. Date of D		ay Year	3. Time of	
	ysici: Medic			BEACHLEY					MARCH	21	2008	1:15	P^{M}
Ex	amin	er	4a. Facility Name (If not institution, give				4b. City, Town, o			4	lc. County of Deat		
			WASHINGTON COUNTY 5. Social Security Number 6. S		e (In yrs. las	t birthday)	If Under 1 Year	HAGERS	Hrs. 8 Date of F	irth	WASHIN 9. Birt	NGTON hplace <i>(St</i> ate o	r Foreian
	eral ctor			□M 2 ∑ F	82	Yrs.	Months Days	Hours N	NOV •		(r) Co	^{uintry)} MARYLAN	
pu ,			Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation			,		10d. Inside Cit	
faryla	ed at	or			roc. Oity,	TOWIT OF LO						1 ☐ Yes	
the M	potifii	Director	MARYLAND WASH	NGTON			HA 10f. Zip Code	GERSTO	wN	10g. C	Citizen of What Co	untry?	
death with the Maryland	st be		13815 EDEN DRIVE					21742			U.S.	Α.	
death	r mu	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. \			? (Specify Yes or Puerto Rican, etc.)	10-	14. Race - Ame Black, White	rican Indian,	
5-0036 72 hours after 'natural', or ite	event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	lo		1 □ Yes 2 <mark>∏</mark> No	Specify:	dente i neam, etc.,		Specify:		
-UUSO hours af	al Ex		15. Decedent's Ed	lucation		16a. Deced	dent's Usual Occup	ation		16b.	Kind of Business/	HITE Industry	
within 72 iene.	Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	(Give life. l	kind of work done DO NOT use retired	during most of d)	working				
d with	t, the	Com	12		′		PAYROLL				HOE MANUE	FACTURII	NG
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A Mer	natic	မှ	ALBERT LUTHER HUT 19a. Informant's Name/Relationship (10h Mailir	na Address (Street		ED CATHER or Rural Route Num			Zin Cada)	
2 2 2	other traumatic		PIERCE W. BEACHLE	**					AGERSTOWN			21742	
Fe, N s 1 and f Health tem 27	other		20a. Method of Disposition		20b. Plac		sition (Name of matory or other place		Date	-	Location - City or		
Pages Pages nent of nt: If it	-		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				O CEMETER	1	/25/2008	BO	ONSBORO	ΜΔΡΥΤ.Δ	NTO
Dalti permit. Departir Importa	any injury o once.		21. Signature of Pineral Service Lice	ee		22	2. Name and Addre	ss of Facility	7606 (National		ND
n ase	E 5		tous Mus	Paul M	. Dear	n B	AST FUNER	RAL HOM			, Maryla		13
			23a. Part1. Enter the disease, com shock, or heart failure. List only	plications that caused one cause on each lir	the death.	Do not ent	er the mode of dyir	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Bet Onset and D	ween
Physic			Immediate Cause (Final disease or condition resulting in death)	a. Acid	05/5							0//00/ 4//0 2	
/Med Exam			1 Counting in dodain,	Due to (or as	a conseque		-						
	46	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (a conseque	5/0 nce of):	<i>y</i> 1						
cuted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.									
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os/ou, tificate be executed g physician and	s the burial-transit	edical		_d									
Sertific ding p	ੇ ਲੋ		IF FEMALE:	23c. If yes, outcome	of pregnance	cv					22d Data of dat	i i o n	
ords, P.O. box requires that the death cer een signed by the attendir	should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant at	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)	У		. "	23d. Date of del Month		/ear
the c	achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown									
S, T	oe det	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ing in the u	nderlying cause giv	en in Part I.			o use contribute to	the cause of d	eath?
COLOS w requires been sign	plno								_ 10] Yes	20 X No 3□ Pr	obably 4 □ U	Jnknown
lecci e law i	e 2 sh	Completed							24a. Wa	onsv	l prior to e	topsy findings a	available ause of
ian: The riffcate ha	, page	Con							pe 1⊡ Yes	formed?	death? No 1 ☐ Yes	2□ No	
Or VITAI HEC Physician: The law rithis certificate has b	recto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: Inpatie	-t 005	7/Outnotion	nt 3□ DOA Oth	OF:	Death (Check only				
Phy er this	eral d	: To	27. Manner of Death	28a. Date of Inju	ry 2	8b. Time o	f 28c. Injur	γ at	ng Home 5 ☐ Re 28d. Describ		6 ∐Other (Spe jury occurred	cify)	
VISION Attending r death.	e fun	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	M 1□	k? Yes 2 □ No					
UIVISIO al or Attendii after death. I Director: A	by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju	ry - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location City or 7	(Street	and Number or Ru	ıral Route Num	ber,
italo Irs aft	lled in			4									
LIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	etely fi	edical	29a. Certifier (Check only one) 1 Certifying Phase 2 Medical Example Medical	ysician: To the best on niner: On the basis of and manner sta	examinatio	edge, deat n and/or in	h occurred at the til vestigation, in my o	me, date and popinion, death	olace, and due to the occurred at the time	e, date a	(s) and manner as and place, and due	stated. to the cause(s	;)
To the To the	ldmos	Me	29b. Signature and title of certifier	10	1		29c. Licens	e number		29d. [Date signed (Mont	h, Day, Year)	
			1/2/	11/ M	//		10	10563	79		3/22,	108	
			30. Name and address of person who	completed cause of de			Print)						
DH-1			Robert J. Marshal	20 5 6-4-	ar's Signatur	**		e., #73	30, Chevy	Cha	ase, MD	20815	
Re	Sta egistr		31. Date filed (MorMAR Y2r)5	2008 32. Hallstra	a Signatu	O A	with				60		

08-02050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larvey Chrispin	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2 1 1 2	1001
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Apply	e of Death J
r en.	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral	Prince George's Hospital Cheverly Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace	(State or
Director	577-23-1875 1	Maryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In	nside City Limits
Aaryland 28a-f show Lat once. ector	Maryland Prince George's Cottage City	Yes 2 No
a or the N		
r death with or items 23 must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indi White, etc.	ian, Black,
s after de ral", or niner mu by Fu	3 Widowed 4 Divorced in residue reer 1 Yes 2 No specify: Specify: Specify:	
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5-0036 ed within 72 hour dygiene. other than "natu the Medical Exan	12th Warehouseman Private	
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. 727 is marked other than numatic event, the Medica To Be Comple	G1 1 -	
212 nould be d Ment is mark tic ever	Claude Jean Flore Chrispin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	ode)
, MD and 2 sh ealth an em 27 i	Claude Jean (Father) 4006 Cottage Terrace, Cottage City MD 2072 20a. Method of Disposition (Disposition (Name of cemetery, Date 20c. Location - City or Town, Suppose the Control of Disposition (Name of cemetery, Date 20c. Location - City or Town, Suppose the Cottage Terrace (Name of cemetery, Date 20c. Location - City or Town, Suppose the Cottage Terrace (Name of cemetery) (Name of cemeter	22 State
nore	1 Burial 2 Cremation 3 Removal from State crematory or other place) Mt. Olivet Cemeters 3/25/2008 Washington DC	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	21. Agnature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Service 9013 Annapolis Road, Lanham MD 20706	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	roximate Interval ween Onset and
/Medical =xaminer	Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):	Death
	Sequentially list conditions, b	
ted Insit Examiner	if any, leading to immediate Due to (or as a consequence of): couse. Enter Underlying Cause (Disease or injury that initiated	
cuted ind transit	events resulting in death) Last Due to (or as a consequence of): d.	
). Box 68760, the death certificate be executed the attending physician and ched for use as the burial - transit Physician/Medical Ex	UNPENDED AMENDED	
3876 rtificate ling phy as the l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Box 687 death certifice the attending p ed for use as th	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)	
D. B. hat the d ed by the etached y Phy		
IS, P.(quires that en signed ald be det	1 Yes 2 ✓ No 3 Probably 4	
Records, The law requires ficate has been significate been significate by page 2 should be Completed	autopsy prior to complet performed? death?	tion of cause of
Vital Rec ysician: The I his certificate I director, page o Be Com		2 No
f Vital Physician r this certi ral director	1 Ves 2 No 1 Inpatient 2 EN/Outpatient 3 DUA 4 Nursing Home 5 Residence 6 Other:	
Division ospital or Attending nours after death. neral Director: After filled in by the function:	2 Accident Investigation 3 Suicide 6 Could not be determined determined (Specify) recidence (Specify) reci	
Di To the Hospital of within 24 hours a To the Funeral I Completely filled		
To the He within 24 within 24 completed	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
Hez	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da.) O.C.M.E. March 14, 2008	y, rear)
(n)	30. Name and address of person who completed cause of death (Item 23a)	
State	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar	B BEACH 4 & 2000 # .	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚣 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DAVID BILLIE CHARLES, JR. 11:13AM MARCH 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 254-60-5309 Director 68 NORTH CAROLINA 2/4/1940 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show at a or 28a-f shot be notified a 1 TYes 2 □ No Director MD PG CLINTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5300 TINKERS CREEK PLACE items 23a 20735 Examiner must Funeral U.S.A hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1958 1 XYes 2 □ No If Yes, Give Year or Dates: American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 💢 No Specify BLACK Specify: 2 3 □ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) POSTAL INSPECTOR US POSTAL SERVICE permit. Pages 1 and 2 should be filed be permit. Pages 1 and Mental Hygis Important: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID B. CHARLES, SR. KATIE TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULINE C. CHARLES/WIFE 5300 TINKERS CREEK PI... CI.INTON MD 20 MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEM. 3/19/08 4 Donation 5 Other (Specify) CLINTON, MD 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service Licenses 6500 ALLENTOWN RD, CAMP em SPRINGS, MD 20748 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. e isease, or o 23a. Part1. Ent. he shock, or hea Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): o **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed and burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician death certificate be Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? Day 5 Other (specify) ☐ Yes 2☐ No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Director: in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined To the Hospital hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

6

State Registrar

MD 7563 Sucratts RD Clinton, mal 20735 VARSHA 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DOO64289

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month MAR 18 2008 Walter David Courtney 0046 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda
If Under 1 Year If Under 24 Hrs. Suburban Hospital Montgomery 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number Months Days Hours Min 11X M 2□ F Director OCT 54 1953 Virginia 223-86-0512 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12600 Gray Eagle Ct. #12 20874 Funeral United Stages 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No unk If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any filury or other traumatic event, the Medical Examine Black. White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify. White þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Pentagon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Davis Anderson Courtney Winnifred Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jesse Allen Courtney/Son 227 N. Van Buren St., Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverdale Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory MAR 25, 2008 Riverdale Park, MD 22 Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD 21. Signature of Funeral Service Licensee M00956 20910 23a. Part1. Ther the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiopulmanary Arrest /Medical Due to (or as a consequence of) Examiner Severe Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ng physician and as the burial-tran Coronary Artery Disease Due to (or as a consequence of) Completed by Physician/Medical Cardiac Arrhythmia IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached the 9☐Unknown 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2【 No 24a. Was an page 2 autopsy performed? res 2 \ No certificate Vital 1∐ Yes Hospital or Attending Physician: director, 86 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛛 No 1 Inpatient Division or Certification: To 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natura! 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5360

State

3/18/08

OURTNO

Registrar

11119 Rockville Pike #100 Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Mohsin Ijaz, MD

31. Date filed (Month, Day, Year) MAR 2 1

March 19, 2008

20850

			For	rieas							nd Mental H		_		
			for State Registrar					Cei	rtificate of	Death		Reg. No	2001	9 10	1946
40	District in		1. Decedent's Nam	ne (First, Middle,	Last)						2. Date of Month	Death Da	y Year	3. Time o	of Death
de de la constante de la const	Physici /Medic		Martha	A. C	ommerfo	ord							, 2008	12:3	5 pm
	Examir	er	4a. Facility Name (If not institution,	give street an	nd number)			4b. City, Town,	or Location of I	Death	40	. County of Dea	ath	
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г	Funeral		5. Social Security N		 Sex 1 M 2 			as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Min. (Month,			rthplace (State ountry)	or Foreign
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	yland low at		10a. State	10b. County			10c. City	, Town or Lo						10d. Inside C	City Limits
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	ems er mi	ne.	11. Marital Status		12. Was	Decedent I ed Forces?	Ever in U.S	S. 13. ¹	Was Decedent of If Yes, specify Cub	Hispanic Origir Dan, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whi		
36	or It	by Fu		ried 2 Marrie	If Ye	Yes 2 1	10		1 ☐ Yes 2 ☐ No				SpecifyWhi		
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examirer must be notified at	g p	3 🙀 Widowed			r or Dates:	-	16a Daga	dent's Usual Occu	nation		1 16h k	(ind of Business		
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	filed Hyg other ent, 1	BeC	17. Father's Name	(First, Middle, L	.ast)			7.1	laryst	18. Mother's	Name (First, Midd			verimei	16
Maryland	2 should be filed w n and Mental Hygie 'Is marked other ti raumatic event, th	To B	William	Henry	Asenbe	ck				Marth	a Johanna	Vand	erlaan		
ary	shou and N		19a. Informant's N	ame/Relationsh	ip (Type. Print	t)		19b. Mailir	ng Address (Stree	t and Number	or Rural Route Nur	nber, City	or Town, State,	Zip Code)	
	and 2 salth a 1 27 Is er trai		Laura J	o Smith	/Daugh	ter		307 1	Whitfield	Road,	Catonsv	.11e,	MD 212	28	
<u>ore</u>	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Dis		2 Damoual	fram Ctata	20b. PI	ace of Dispo	sition (Name of matory or other pla	ice)	Date March 20	20c. L	ocation - City o	r Town, State	
<u><u>E</u></u>	Page ment c			Gremation 5 □ Other (Sp		nom State	Me	tropo	litan Cre	!			lexandr	ia, Vir	rginia
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21. Signature of F	uneral Service L	icensee)		22 F1	2. Name and Addr	ess of Facility	ns Funera				
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ĸ			23a. Part1. Enter t such, or hea	th isease, or cart failure. List o	complications only one cause	that caused on each lin	the death e.	. Do not nt	er the mode of dy	ing, such as ca	rdiac or respirator	arrest,		Approxima Interval Be	etween
葡	Physician		Immediate Cause disease or condition	on	a A	SPA	YX1	at.	270					Onset and	Death
	/Medical Examiner		resulting in death)		Du	ue to or as	consequ	ence of):					,	201	12
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P.O.	that the dened by the a	Physician/Medi	9 ☐ Unknowr		9□1	Unknown									
	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	by P	Part II. Other signi	ificant conditio	ns contributing	to death bu	ut not resu	Iting in the u	nderlying cause gi	ven in Part I.	23e. Di	d tobacco	use contribute	to the cause of	death?
ğ	w require been sig should b										1[Yes 2	2 □ No 3 □ F	robably 4	Unknown
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Division	Attending r death. ector: Afte by the fune	Certification:	2 Accident	investiga	ation mo	r 193	२००४।	unk	AM 1	Yes 2 No	hang	المراز	- 5414 1	mylick	201
Ž	or Attendater death Director: /	ij	3 Sulcide 4 ☐Homicide	determin	20C.	Place of injubuilding, etc	c. (Snecify) /	eet, factory, office		28f. Location City or	(Street a own, Stat	nd Number or F	Rural Route Nu	mber Rd.
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and	title of certifier	and /	manner sta	nea.		29c. Licen	se number		29d D	ate signed (Mor	ith. Dav. Year)	
		_	The same and	~ 1	(A		0045	X		r 20	200	
	10		30. Name and add	rose of norser	Jale completed	LOGUED OF T	moth date	DMG		0 / <	9	J . AU	, ,		
				echer,	MD 2	101 Me	dica	l Park	Drive,	#304,	Silver Sp	ring	, MD 20	902	

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month AR 2 1 2008

32. Registrar's Signature

		State of Mary	•			∕lental Hy	giene			
		1 — State Registrar	Cer	tificate of l	Death		Reg. No.	008	10	94
Physici	an	Decedent's Name (First, Middle, Last)	•			2. Date of De Month	Day	Year	3. Time of	
/Medic	al	Robert M.	Cornett	4h City Town or	Location of Double	March		2008 y of Death	1140	A M
Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		_			
Funeral		2818 Old Elk Neck Road 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	l Ce	9. Birthp	lace (State o	r Foreign
Director		218-40-2306 ¹ X ¹ M ² □ F 65	Yrs.	Months Days	Hours Min.	March 29	y, Year)	Vir	ginia	
pu ,		Usual Residence of Decedent 10a. State 10b. County 10	Oite Terre exten							
aryla shov	<u>-</u>	10a. State 10b. County 10c	c. City, Town or Loc	ation				1	0d. Inside Cit 1 ☐ Yes	
the M 28a-f	Director	Maryland Cecil 10e. Street and Number	E1kton	10f. Zip Code			10g. Citizen of	What Cour		
with ta or	ă	2818 Old Elk Neck Road		21921				ed Sta		
be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No		ce - Americ		
or iter	골	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No				o Rican, etc.)		ick, White,	etc.	
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within sne.	d m	Elementary/Secondary (0-12) College (1-4or 5+)			•			nobile Eactui		
Hygid Hygid		1 Z 17. Father's Name (First, Middle, Last)	l Ma.	intenance	18. Mother's Nam	ne (First, Middle			TIIg	
d be ental	To Be	Raymond Luther Cornett			Rosale	e Caldwe	11	,		
shou inc M in ar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a				, State, Zip	Code)	
and 2 alth a 27 is		Carolyn H. Cornett/Wife	2818	Old Elk	Neck Road	d. Elkto	on, MD	21921	<u>.</u>	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 271s nerthed other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		· · ·	Ob. Place of Dispos	sition (Name of		Date	20c. Location	- City or To	wn, State	
Pag nent ant: It		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (<i>Specify</i>)	Lmmaculat	e P. Comoto:	2008	$\frac{1}{3}$ 2,	Cherry	Hi11	. MD	
ermit. sparti sports y inj		21. Signature of Funeral Service Licensee	22 H-i	Name and Addres	for Fund	orale I	Α .		1	
205 # 9		Donied S. Hicko	10	Name and Address cks Home 3 W. Sto	ckton St	ceet, El	kton, M	ID 21	921	
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Bety Onset and D	veen Jeath
Physician	H	Immediate Cause (Final disease or condition resulting in death)	atic 1	Ion Sual	0 600	Lung Co	noon		Onsor and E	rouiii
/Medical Examiner		Due to (or as a co	nsequence of);			1				
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ficate be executed physician and sthe burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 🗆	Ectopic pregnancy			I .	ate of delive	•	⁄ear
ne deg the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	e of death 5□	Other (specify)			144	Olitic	Day 1	Gai
The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but no	ot resulting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of de	eath?
uires tha signed	d by		3	,		12			ably 4 □L	
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, , L		25. Was case referred to medical			26. Place of Dea	1 Yes	2 1 No	1 ☐ Yes	2 - NO	
ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	: 3 □ DOA Othe		ome 5 Resi		her (Specif	v)	
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endir aath. or; Af he fur	Certification:	2 Accident investigation		M 1□	Yes 2 □ No					
r Att ter de irect irect	ti lic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rura	l Route Num	ber,
oital o										
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.	y knowledge, death Imination and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place	nanner as s , and due to	tated. the cause(s	;)
o the ithin 2 o the omple	Mec	29b. Signature and title of certifier		29c. License	number		29d. Date sign	ed (Month.	Day, Year)	
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	-	30. Name and address of person who completed cause of death	(Item 23a) (Type F)	-//	/ 3		
		Martha Hosford, M.D., 111 W.	High Str	eet, Suit	ce 104, E	lkton,	MD 219	21		
Sta	te	31. Date filed (Month, Day, Year) 82. Registrar's	Signature 🥒	K 0	· _ <u> </u>					
Registr	ar	APR 0 4 2008	OF ANDROVE		<u></u>					
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State Registrar

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Avenue Cumberland, Maryland 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L25 Kent

Sunil Gueta M.D. L25 Ken 31. Date filed (Month, Day, Year) 2. Registrar's Signature

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Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD

32. Pagistrar's Signature

Genevieve Wroblewski

D0064615

1355 Piccard Drive Rockville, MD 20852

March 17, 2008

State of Maryland / Department of Health and Mental Hygiene 095 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 14, 2008 Year CHIBOWSKI Lea 6:25 P. M /Medical 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Arcola Health Care Center 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🕽 F 89 090-54-2150 Director Poland Feb. 6, 1919 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Silver Spring MD Montgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20902 607 Hillsboro Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Λ Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White <u>م</u> 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 should be filed w h and Mental Hygieu 7 Is marked other tt permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sora (unknown) Moshe Yitzchak Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Flyral Boute Number, City or Tome, State 3002) / daughter Sara Hyatt Method of Disposition

| Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date |
| Method of Disposition (Name of cemetery, crematory or other place) | Date |
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| Method of Disposition (Name of cemetery) |
| Method of Disposition (Nam 20a. Method of Disposition 20c. Location - City or Town, State Rosedale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Fervi Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of):
Alzheimer's Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to for as a consisquence off Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as aftending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pate has t autopsy performed? Yes 2☐No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 14, 2008 D52261 10 use of death (Item 23a) (Type, Print) Hugo Circle, Silver Spring, MD 30. Name and address of person who completed c. Alan R. Segal, MD, 1517 20906-5917 Restrar's Signature State 0 2008 Registrar

			State Registrar	Maryland / D	epartment Certificate				Reg. No.	008	10952
	Physici		1. Decedent's Name (First, Middle, Last) Michael Joseph Capuano					2. Date of De Month	Day	2008	3. Time of Death 10:28 PM
	/Medi Examir		4a. Facility Name (If not institution, give street and numb	oer)	4b. City, To	own, or Locatio	on of Death			ty of Death	10120
			Atlantic General Hospital		Berl					cester	
	Funeral Director		5. Social Security Number 6. Sex 102-30-4909 1 ☑ M 2 ☐ F	Age (In yrs. last birth	rs. If Under 1		ter 24 Hrs. s Min.	8. Date of Bir (Month, Da 11/12/	th iy, Year)	9. Birthp Cour	nlace (State or Foreign
			Usual Residence of Decedent					11/12/	1939		NY
	within 72 hours after death with the Maryland ans. then "naturel", or items 23s or 28s-f ehow in Medical Examiner must be multined at	_	10a. State 10b. County	10c. City, Town						1	0d. Inside City Limits
	rith the Maryla or 28a-f ethor	Director	MD Worcester 10e. Street and Number	Berli					10. 000	(111)	1 ☐ Yes 2 ☐XNo
20	with t	ā	23 Harlan Trace		10f. Zip C				10g. Citizen o	f What Cour	ntry?
328	ier death items 23	Funeral	11 Marital Status 12. Was Deced	ent Ever in U.S.	13. Was Deceder If Yes, specify		Origin? (Spe	cify Yes or No	USA - 14. 8	ace - Americ	
a	or its		Armed Force 1 □ Never Married 2 □ Married 1 ☒ Yes 2 If Yes, Give		If Yes, specify			Rican, etc.)		ack, White,	
139	"natural",	d by	3 Wildowed 4 Divorced Year or Date						Spec	MILL	
20 0 P	in 72	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usua! (Give kind of work life. DO NOT use	Occupation done during m retired)	ost of worki	ing	16b. Kind of	Business/Ind	dustry
2 25	d with giene.	mo	Elementary/Secondary (0-12) College (1-4	or 5+}	nporter	,			Reta	il	
122/	be filed withir trail Hygiene.	Bec	17. Father's Name (First, Middle, Last)					(First, Middle	Maiden Suma	ame)	
- 03		2	Ralph Capuano			<u> </u>	hel T				
100	t and 2 should thealth and Mer thealth and Mer to the traumatic		19a. Informant's Name/Relationship (Type, Print) Deedre Capuano / daughter		Mailing Address (S 25 Newtor				-		
00	s 1 and of Health litem 27 other tr		20a. Method of Disposition	20h Place of I	Disposition (Name	n of		Date	20c. Location		
000 000	00		1XXeurial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ale	f Heaven	er place)	3/27	/2008	Dagsb	oro D	F
+	y inju		21. Signature Funeral Service Licensee	- Jaave o	22. Name and	Address of Fac					
α	83188		MAR Macaso		108 Wi					11	
500	Physician /Medical			ised the death. Do not the line. SUCSULT as a consequence of	CO7C (7		uith	()	75	Approximate Interval Between Onset and Death
102-30-4	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of	-mA						
Capucino I	that the death certific led by the attending p detached for use as	Physician/Med		n 2 Fetal death	3 □Ectopic preg 5 □ Other (spec					ate of delive	ory Day Year
20 P	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to deal	th but not resulting in	the underlying cau	se given in Pai	nt I.		obacco use co Yes 2 No	'	ne cause of death?
Michael Co	: The law r cate has be page 2 sh	Completed						24a. Was autor perfo 1 ☐ Yes	an 24b	Were autoprior to condeath?	psy findings available impletion of cause of
جُ جُ	Physician: Th this certificate ral director, pag	Be .	25. Was case referred to medical examiner?	-1		Othor		(Check only o			
		n; To	1			i. Injury at Work?		ne 5 Resident			/)
<u>.</u>	Attending I r death. ector: After by the funer	atio	1 Matural 5 Pending (Month, 2 Accident investigation	Day Year) Inj	ury M	Work? 1 ∐ Yes 2 ∣	□No				
Division	To the Hospital or Attendi within 24 hours atten death. To the Euneral Director: A completely filled in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of building	Injury - At home, farr , etc. (Specify)	n, street, factory, o	office		28f. Location (: City or Tou	Street and Nun vn, State)	nber or Rura	il Route Number,
	the Hosp nin 24 hou the Funer npletely fil	ledicai	29a. Certifier (Check only one) 1 Certifying Physician: To the brack only one) 1 Medical Examiner: On the bass and manner	s of examination and	or investigation, in	n my opinion, d	leath occurr	ed at the time,	date and place	e, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier)	1	icense numbe			29d. Date sign		
			Mulle	- W	/ Dist	12462			3	-24	. 00
85	15+1		30. Name and address of person who completed cause Enway CATIMESA: WD	of death (Item 25a) (T 10324 02 jstrar's Signature	ype, rint) 1) OCEYM	1ary	BWI).	BEKE	N, K	0218	1/
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	Registr	ar	MAR 2 4 2008	new Is.	Sparke	,					

DHMH 17 Rev 1/2001

			For State of Mar State Registrar	yland / Depa <i>Cer</i>	rtment of H <i>tificate of l</i>			giene Reg. No.2	08 10954
	Di este		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
L	Physici /Medic		Mildred Pauline COLLINS				MARCH	23 2	10:43 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County	of Death
-	C Francis	Ш	9624 Downsville Pike 5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	Hager If Under 1 Year	stown If Under 24 Hrs.	8. Date of Birt	Wash	ington 9. Birthplace (State or Foreign
	Funeral Director		1□M 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	90 Yrs.	Months Days	Hours Min.	(Month, Day Aug. 26	v, Year)	Country) Pennsylvania
	pc _		Usual Residence of Decedent				nug. Z	0 1011	
	arylar show d at	۲	10a. State 10b. County	0c. City, Town or Loc	ation				10d. Inside City Limits 1X Yes 2 □ No
	the M 28a-f otifie	Directo	Maryland Washington 10e. Street and Number	Hager				40 000	
	with is or it				10f. Zip Code			10g. Citizen of V	vnat Country?
	ms 20	Funeral	604 E. Wilson Boulevard 11. Marital Status 12. Was Decedent Ev	er in U.S. 13. W		740 lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race	e - American Indian,
9	be filed within 72 hours after death with the Maryland the Hylgiene. And the Hylgiene. And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married Armed Forces? 1 □ Yes 2 No If Yes, Give				Rican, etc.)		k, White, etc.
5-0036	ıours ıral",	d by	3 ₩ Widowed 4 □ Divorced Year or Dates:		□Yes 2X No	Specify:		Specify	White
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121	withir iene. than the M	duc	Elementary/Secondary (0-12) College (1-4or 5+)			1)		77	
0	~ - 0 9	Be C	17. Father's Name (First, Middle, Last)	П	emaker	18. Mother's Nam	e (First, Middle,		er own home
Maryland 21	ould be Mental arked o	TO B	Artie E. Mathna			Karrie	May Var	ner	
ar)	2 should and Men I Is marke		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street a	and Number or Ru			State, Zip Code)
	s 1 and f Health item 27 other tr		LaFawn Hite - Daughter	7537	McClella	n Avenue,	Boonsh	oro, Mar	ryland 21713
٥	90 = 5		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, crem	ition (Name of atory or other plac	ce)	Date	20c. Location -	City or Town, State
Baltimore,	iit. Pa artmer artanti ortanti injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Cedar Law	n Mem. Pa				own, Maryland
g	permit. Pag Department Important: any injury o) Soft MM	_ / /		son Blvd.	Minnich		
	1200		23a. Part1. Enter the disease, or compli ations that caused the	e death. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
8.5	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	a Car	10 2	,			Onset and Death
	/Medical		resulting in death) a. Due to (or as a death)	-	- C				vnornas
	Examiner		Sequentially list conditions. b. ###	erlan	8201		_		Xears
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	. (0	ano	4		Ya a
_ IIN	xecul and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a c	consequence of):			<u> </u>		months.
08/90	ificate be executed g physician and as the burial-transit		d Dei	neul	la	j			months.
200		fedical							
X P P	th cert tending r use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the post 12 mer/like? 23c. If yes, outcome pf 1 □ Live birth 2	pregnancy □ Fetal death 3 □ I	Ectopic pregnancy	,			e of delivery
	the attenned for u	Sici	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Mor	nth Day Year
7	that the set by set act		Part II. Other significant conditions contributing to death but r	not resulting in the und	derlying cause give	en in Part I	23e Did to	ibacco use contr	ribute to the cause of death?
coras,	w requires that the death certil been signed by the attending should be detached for use a	d by	(Vanemic	Pain]. ~	DIT 111 CALL	1 🗆 Y		3 □ Probably 4 □Unknown
	law req as been 2 shoul	ete	3000		V		24a. Was a		Vere autopsy findings available
r	The la	Completed		·			autop perfor	sy p	prior to completion of cause of leath?
	an: Trifficat tor, pa	Be C	25. Was case referred to medical			26. Place of Deat	1 Yes		☐ Yes 2☐ No
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0	ng Pl		27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Y	(ear) 28b. Time of Injury	28c. Injury Work			ow injury occurre	1100
SION	ftendi leath. for: / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	****		Yes 2 No			
5	or Al after o Direc in by	Certification:	4 Homicide determined 28e. Place of injury building, etc. (At home, farm, streets Specify) 	et, ractory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Route Number,
			29a. Certiffer 1 Certifying Physician: To the best of r	ny knowledge, death	occurred at the tim	ne, date and place.	and due to the	cause(s) and ma	nner as stated.
d	n 24 h	Medical	(Check only 2 Medical Examiner: On the basis of examiner and manner state	kamination and/or inve	estigation, in my o	pinion, death occur	rred at the time,	date and place, a	and due to the cause(s)
	vithi To th	Ž	29b. Signature and title of certifier	^	29c. License	- 0			(Month, Day, Year)
			My an My)	No	004503		march.	25 2008
5	1-2		30. Name and address of person who completed cause of deal	h (Item 23a) (Type, P	rint) 4-C 10.	ter sty	re F	le ta	Censtown AD
	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's	Signature / 17 (- 3000	1		1 21742
	Registra	-	MAR 2 5 2008	An A	Carlo		0		~

08-02441 Mark L. Capano Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10955

air L. O	арапо		- For State	Certific	cate of Death		Reg	. No.	000 1000
n Aup	nysicia	_	legistrar 1. Decedent's Name (First, Middle,La	st)			Date of Death Month	Day Year	3. Time of Death 0558 hrs
	Exami	ner	Mark Louis C		T	or Location of D	March 28, 2	4c. County of	
		•	 Facility Name (if not institution, givestern Md. Health Syst 		Cumberla		eatti	Allegany	
			5. Social Security Number 6. S		irthday) If Under 1	ear If Under 2	4Hrs. 8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or
	neral ector	- 1				ays Hours	Min. Jan. 3		Foreign CountryMary1and
		-	220-08-4696 1 Usual Residence of Decedent	XM 2 F 23			10 4111 3	,	
	any	Ī	10a. State 10b. County	10c. City, Tow					10d. Inside City Limits 1 Yes 2 XXNo
pu	* "	<u> </u>	Maryland Cecil	Po	rt Deposit				
7 lary lar	at on	Director	10e. Street and Number		10f. Zip Coo			g. Citizen of Wha	· I
the N	a or or		1379 Theodore		219			United S	- American Indian, Black,
with	be n	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent o	Hispanic Origin Iban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	White,	
r deat	or ite	핊	**	1 Yes 2 X No	1 Yes 2XX	No specify:		Specify:	White
rs afte	ural"	à	Widowed 4 Divorce 15. Decedent's Education (Specify	1 or Dates:	a. Decedent's Usual Occ	upation (Give kin	d of work done	16b. Kind of Bus	siness/Industry
2 hou	"nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working		e retired)	0	cuction
036 ithin	Hygiene. other than the Medical	ш	9		Concrete F		Name (First, Middle, N		
5-0 iled w	Hygie d othe		17. Father's Name (First, Middle, Lat Mark Louis Capa				ty Miller	naiden Sumame,	
21215-0036 Puld be filed within 7	Mental Hygien marked other c event, the M	o Be	19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number	er or Rural Route Nun	ber, City or Tow	n, State, Zip Code)
MD 21215-0036 MD 212116-within 72 hours after death with the Maryland	of Health and Mental Hygiene. If item 27 is marked other there there transactions to the Med	-	Betty Capano-Wil		1379 Theod	ore Road	d, Port De	posit, N	Maryland 21903
e, Z	Health item	min	20a. Method of Disposition	1	ce of Disposition (Name on matory or other place)	of cemetery,	March		City or Town, State
Baltimore,	Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		1 X Burial 2 Cremation 3 4 Donation 5 Other Speci	Nort	h East Meth	odist	31, 2008	North I	East, Maryland
altin	portar ury or		21. Sig ur Service Li		22. Name and Ad		Crouch F		
ă ă	F P P		11/684.6		127_Sout	h Main	Street. No	rth east	t. Marvland2190
	sician		failure. List only one cause on		o not enter the mode of d	yilig, such as car	diac of respiratory an	00t, 01100tt, 01111	Between Onset and Death
	edical ıminer	B N	Immediate Cause (Final disease or condition resulting in death)	a. Asphyxia Due to (or as a consequence of):					
			Sequentially list conditions,	b.					
		ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
	_	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
patro	ysician and burial - transit		,	d				 	
	/sician a	Medical	X UNPENDED	X AMENDED , 27, 28a-f,		.6/08 TT		Lood Date of	f delivor.
760,	phys the bi	≥	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnant	ncy ₂ Fetal death	3 Ectopic	pregnancy	23d. Date of Month	
Box 687	e attending for use as t	Physician/	past 12 months?	4 Pregnant at time of death					
Bo	the att	hysi	1 Yes 2 No 9 Unkno	9 Olikilowii	W. J. H	was siven in Per	+1 23e Did	tobacco use cont	tribute to the cause of death?
o j	ned by the detached 1		Part II. Other significant condition	ns contributing to death but not resi	ulting in the underlying c	ause given iin ai			Probably 4 V Unknown
S,	quires unar en signed ald be deta	70					24a. Was	L.	Were autopsy findings available
oro	has be	g						ormed?	prior to completion of cause of death? 1 Yes 2 No
Rec	certificate ector, page	5			26	.Place of Death (1	2No	1 65 2 110
tal	s certil rector	a B	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient 3 DO	Othor	Nursing Home 5	Residence 6	✔ Other: Scene
<u> </u>	Ing rnysician: The law requirements of the certificate has been a funeral director, page 2 should	<u>ا</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury		c. Injury at Work	? 28d. Describe	how injury occu	rred
uc :	ith. r: Af	<u>.</u>	1 Natural 5 Pendin		and 4:45 am	1 Yes 2 X		t was asph	
Division of Vital Records, P.O.	or Attencafter death Director:	fica	2 Accident Investi 3 Suicide 6 Could	gation 28e Place of Injury - At hon		office building, et	c. 28f. Location or Town	(Street and Num State) WeSte	ber of Rural Route Number, City ern MD Corr. Inst.
ِ ۾َ	ospital or Attend hours after death meral Director: v filled in by the	Certification:	4 X Homicide determ	nined (Specify) jail cel			Cresap	town, MD	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			vsician: To the best of my knowledge inner:On the basis of examination and	e, death occurred at the t d/or investigation, in my	me, date and pla pinion, death oc	ace, and due to the ca curred at the time, da	use(s) and mann te and place, and	er as stated. I due to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner stated.		License number			gned (Month, Day, Year)
		2	D AA Al	'all 00 A		O.C.M.E.		March 29	, 2008
			30 Name and address of person v	who completed cause of death (Item 2	23a)			1	
			Pamela E. Southall, MI	 Assistant Medical Exam 	niner 111 Penn	Street, Baltim	nore, MD 21201	·	
		State	11 00 11 0 7	Registrar's Signatur	South				
	- 7	etra	- MIN V X 4	WITH MULTIPLE AND AND	A4 (2)				

DHMH 17 Rev 1/2001 OCME 2000

ORIGINAL

OCME

					2	Tie		Da	-46-	
J. No.	2	0	0	8		Section	0	9	5	

12:15 P™

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

4 Unknown

Month

1 ☐ Yes 2 X No

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 3 20^{y} John Deppisch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10344 Tudor Rd. Worcester Ocean City 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 4/24/1919 **Funeral** Days 1**X**M 2□F Director 213-01-4384 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

When than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10344 Tudor Rd. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Technician US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic es Harry Deppisch Mary Tragesser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. White / friend 12425 Kent Rd., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Eastern Shore Vet Cem 3/25/2008 4 Donation 5 Dother (Specify) Hurlock, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service License 108 William St., Berlin, MD 21811 LATA 23a art1. Enter the dise, see or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail are list only one cause on each line. Immediate Cause (Final **Physician** Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit IHTN Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Be

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director:

							24a. Was an autopsy performed? 1□ Yes 2□ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referr		ed to medical		26. Place of Death (Check only one)								
	examiner? 1 ☐ Yes 2 ☐ 1	Vo	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 🗆 [OOA Other: 4 Nursing H	Iome 5 Residence 6	S □Other (Specify)				
	Manner of Death Natural Death	5 ☐ Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred				
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - building, etc. (S		et, facto	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,					
29	a. Certifier					ed at the time, date and place		and manner as stated.				

29c. License number

DO058701

BA9+1

Jason State

2

Certification:

Medical

31. Date filed (Month, Day, Registrar

29b. Signature and title of certifier

Philadelphia Ave, 1001 32. Registrar's Signature

MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-02349

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James W. Davies State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day March 24, 2008 Year 2210 hrs Medical Examiner James Wendling Davies 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany 11003 Welsh Hill Road Frostburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Director Maryland 215-26-6826 76 November 22, 1931 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Frostburg or items 23a or 28a-f show must be notified at once. Maryland Allegany 1 Yes 2 No imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If iten 27 is marked other than "natural", or items 23a or 28a-f she Director 10e. Street and Number 11003 Welsh Hill Road 10f. Zip Code 10g. Citizen of What Country 21532-U.S.A. Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married Yes 2 No White Give Year Korzan War 2 No specify: Specify Divorced Yes marked other than "natural", ic event, the Medical Examiner ੬ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) unknown banking 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ethel Miller Wendling Francis Davies Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic 21532-Frostburg Maryland Elizabeth Norris 717 Washington Street 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State March 28, 2008 permit. Pages
Department of
Important: I Frostburg Memorial Park Frostburg Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Compicated by Hypothermia Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial: transit completely filled in by the funeral director, page 2 should be detached for use as the burial: transit Physician/Medical UNPENDED AMENDED P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 2 1 Yes No 28a. Date of Injury (Month, Day Year) Mar 24, 2008 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Exposed to cold Division Natural 2210 hrs Yes 2 ✔ No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 11003 Welsh Hill Road, Frostburg, Md determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examin 1.9n the asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) March 25, 2008 O.C.M.E. mi 2 30. Name and address of person who completed cause of death (Item 23a) Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 David Fowler M.D. 31. Date filed (Month, Day, Year) Pagistrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 Bel1 March 19. 0ra Darago /Medical 6:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Calvert Prince Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 233-74-2774 95 11-23-1912 North Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Hospital Road 20678 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No þ Specify 3 ₩ Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental in Important: If item 27 is marken any Injury or a system. 2 should be finance and Mental F Wyatt 2 Mary Louise Royal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl J. Darago, son 1871 Emmanuel Church Road, Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roselawn Mem. Gardens 03-25-2008 Princeton, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. O/Wo 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroscienotic Cardio voecular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes mellitu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Dementio 24a. Was an has page 2 autopsy performed certificate 1∐ Yes 2 1 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 17 No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760. Funeral Director: After Hospital or Attending death. the filled in by after (within 24 hours To the

Medical State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eale Churcht

and manner stated.

wano.

31. Date filed (Month, Day, Year) 2008

Ceyco

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

32. Register's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

50653.

Road

GYAN G. SURANA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3-20-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Warren E. Darby 14, 2008 /Medical Mar. 8:08 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 75 212-28-2310 Director Mar. 13,1933 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Anne Arundel Pasadena Director 1 ☐ Yes 2 → No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ss 1 and 2 should be filed within 72 hours after death with is of Health and Mental Hyglene. Item 72 is marked other than "natural", or items 23a or cother traumatic event, the Medical Examiner must be no other traumatic event, the Medical Examiner must be no "natural", or items 23a or edical Examiner must be r 105 East Pasadena Road 21122 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City Police 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie W. Darby Alice M. Bohren ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ray E. Darby/ Son 1628 Courtfield Lane Collierville, TN 38017 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mar. 19, Glen Burnie, Maryland 2008 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Foneral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive **Physician** Chronic Pulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): Examiner the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Mpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. after death Director: in by To the Hospital within 24 hours a To the Funeral L

Baltimore, Maryland 21215-0036

Medical State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of pers in

29b. Signature and title of certifier

29a. Certifier (Check only one)

and manner stated.

who completed cause of leath (Item 23a) (Type, Print) STEPHEN OLE TO

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

08-02352 Yvonne Dixon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vonne Dixon	State of Maryland / Department of H 1-For State Certificate of Description		08 1096
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year March 25, 2008	3. Time of Death 0250 hrs
	4a. Facility Name (if not institution, give street and number) 4b. 0	ty, Town, or Location of Death 4c. County of Death	ath
Funeral		reensboro Caroline Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. t	Birthplace (State or
Funeral Director	219-70-7822 1 M 2 K 47 Yrs.	onths Days Hours Min. 7/12/1960	eign Country MD
ow any	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	10e. Street and Number 13200 Greensboro Road, Lot #1	Zip Code 10g. Citizen of What Co 21639 United St	ountry?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f shrent, the Medical Examiner must be notified at once	11. Marital Status X 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Deceden	cedent of Hispanic Origin? (Specify Yes or No- cecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am White, etc Whit	erican Indian, Black,
urs after d tural", or aminer m	3 Widowed 4 Divorced in Yes, Give Year 1 900 11 Yes	2 No specify: Specify: sual Occupation (Give kind of work done 16b. Kind of Busines	
5-0036 Isolation 72 hours after Hygiene Argiene "natural", the Medical Examiner	Elementary/Secondary (0-12) 12 H.S. Grad College (1-4 or 5+) Line Wo	rker Food Pro	ocessing
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 12 is marked other than market event, the Andelean	m Earl Francis Highlit	18.Mother's Name (First, Middle, Maiden Surname) Ruth Elizabeth Henderson	
MD 21 d 2 should th and Me n 27 is ma aumatic ev		ress (Street and Number or Rural Route Number, City or Town, St nard Ave., Greensboro, MD 21639	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other traumatic event, the Medical Pages.	20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other Specify:		
Balti permit. Departn Imports injury c	21. Signiture of Funeral Service Licensee 22. Name No. re	and Address of Facility Funeral Home, P.A., 12 S.Second St., Des	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of Chronic Alcoholism	ode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Sxaminer	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
ecuted and transit			
60, ate be exchysician hysician e burial	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of deliv	/en/
certifica	23b. Was decedent pregnant in the past 12 months?		Day Year
by the attentiched for us	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I. 23e. Did tobacco use contribute	to the cause of death?
ires that the signed by lbe detach	d by	1 Yes 2 No 3 F	Probably 4 🗹 Unknown
cords law requ has been 2 should	ompleted ———————————————————————————————————	autopsy prior performed? death	
	25. Was case referred to medical	1 Yes 2 No 1 Y	res 2 No
n of Vital Iding Physician: h. After this certifi	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing Home 5 Residence 6 Ot	her: Scene
on of adding Plate.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	28c. Injury at Work? 28d. Describe how injury occurred	
Division pital or Attendi ours after death. creal Director: /	1 V Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) (Month, Day, Year) 28e. Place of Injury - At home, farm, street, fit (Specify)	ctory, office building, etc. 28f. Location (Street and Number or or Town, State)	Rural Route Number, City
합의 함께 (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, and due to the cause(s) and manner as s n my opinion, death occurred at the time, date and place, and due to	stated. the cause(s)
To Sou	and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (
	Pati. Uw Holloh on	O.C.M.E. March 25, 200	8
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 1	1 Penn Street, Baltimore, MD 21201	
Stat Registra			

VOID

CERTIFICATE

2008-10961

SEE

CERTIFICATE #

2008 - 11662

			For State Registrer			ertificate of		R	eg. No. 2	006	10	96
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Deat Month	Day	Year	3. Time of	Death
	/Medic	al	Madlyn Grabows			4b Oth Town	or Location of Death	March 18,		u of Dooth	7:45 a	IVI
	Examin	er	Manor Care-Bethesda	. Facility Name (If not institution, give street and number) Manor Care—Bethesda					4c. County of Death Montgomery			
žini:	Funeral Director		388-07-3725	7. Age ((In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) Sept. 18	, Year) , 1913	9. Birthpl Count Michi		Foreign
Ind 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. do theire than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	and w		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or L	ocation				10	0d. Inside Cit	y Limits
	Maryl f sho	Ď	Maryland Montor	7mo137	ī	ensingtan					1 □Yes	2 XX No
	the 28a-	rec	10e. Street and Number	AIR:1.y	1	10f. Zip Code		1	0g. Citizen of	What Coun	try?	
	3a or	Funeral Director	9900 Hillridge Drive	9		2089	95		U	SA		
	ms 2	ner	11. Marital Status	12. Was Decedent Ev	er in U.S. 13	. Was Decedent of I	Hispanic Origin? (Spectar, Mexican, Puerto F	cify Yes or No-		ce - America		
	urs after al", or ite Examine	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		1 ☐ Yes 21 No		ilcan, etc.)		ick, White, o White	etc.	
2	72 hc natul Ileal	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dec	edent's Usual Occup	pation during most of working	na I	16b. Kind of E		lustry	
7	ithin ne.	np(e	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of workin d)					
7	ed w ygier her th	ខ្ញ	12		Adm	unistrative		(P) 4 4 5 4 11 -	Cong			
Ē	e = 5 = 6	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			me)		
<u>\{ \} \</u>	2 should be and Mental Is marked or raumatic eve	은	George Grabowsky		T		Gertrude					
Maryland	es 1 and 2 should to of Health and Ment of Item 27 Is marked or other traumatic		19a. Informant's Name/Relationship (T)		19b. Mai	ling Address (Street	and Number or Rura	l Route Numbe	r, City or Towr	n, State, Zip	Code)	
	l and Health mm 27 Ther t		Jane M. Fall-Dickson/I	Daughter			Drive, Kensin		20895 20c. Location	City or To	um State	
Baltimore,	Pag ment ant: I	/	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)			osition (Name of ematory or other pla eaven Cemete	Haiten	24,		-	wn, State	and_
ăalt	permit. Departi Importi any inj once.		21. Signature of Funeral Service Licens	ee 1 4 4 4		P2. Name and Addre	ess of Facility Collins Fune	ral Home		*	9,	
	₽0 <u>= </u> @ ø		1 Contract	0000			sity Blvd. W.			MD 209		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line	ne death. Do not e	nter the mode of dyi	ng, such as cardiac o	r respiratory arr	est,		Approximate Interval Bety Onset and D	ween
1	Physician	1111	Immediate Cause (Final disease or condition resulting in death)	a. Multi-C	ryan Failu	e						
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
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	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):							
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09/89	tificate be executed g physician and as the burial-transit	ledical		d								
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X R O	attending	ciar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		☐Ectopic pregnand ☐ Other (specify) _	;y			onth	-	Year
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Vital Records,	quires in signe	d by	Osteoporosis					1 № Y	es 2 □ No	3 ☐ Prob	ably 4 □L	Jnknown
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Ž	sician: The law certificate has birector, page 2 s	Щ						autops	med?	prior to cor death?	mpletion of ca	ause of
ta	(0 0		25. Was case referred to medical				26. Place of Death		2 XNo	1 🗆 Yes	2 NO	
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Ö	g Phys er this eral dii		27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju		8d. Describe h			"	
DIVISION	or Attending Futer death. Director: After in by the funer.	tio	1 XNatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		Yes 2 □ No					
	or Attendatter death Director:	fice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury	y - At home, farm, s	treet, factory, office	2	8f. Location (S		nber or Rura	l Route Num	ber,
É	al or s after if Direction b	Certification:	4 🗆 Hofflicide	building, etc.	(Зресну)			City or Tow	n, State)			
	To the Hospital within 24 hours at To the Funeral Completely filled in	Medical C	29a. Certifier Check only one)	/siclen: To the best of iner: On the basis of e and manner state	examination and/or	ath occurred et the t investigation, in my	ime, date and place, a opinion, death occurre	and due to the c ed at the time, c	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s	;)
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)	15		1 / tu	Q,	oth (there (COs) (True	019	1609		3.19	-08		
			30. Name and address of person who can Raman Tulvi, MD 108:	10 Darnestown	Road, #202		ourg, MD 2087	8				
	Sta Registi	_	31. Date filed (Month, Day, Year) MAR 2 0 2	32. Resistrar	's Signature	Courte						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 18, 2008 March 7:05 PM Marjorie Earnshaw Farral1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Months 1 □ M 2 F Yrs. April 12,1921 219-58-8174 86 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Calvert Solomons 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1225 Hollidge 20688 USA Funeral 14. Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 White Specify: 2 3 XWidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pickney A. Earnshaw, Sr. Bertha M. Rees 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Clark/Daughter Box 1670, Solomons, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ignatius Cemetery 3/26/08 Port Tobacco, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01458 21. Signature of Funeral Service Ligens AREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata.MD 20646 23a. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MPOXIA Physician /Medical Due to (or as a con uence of): Fibullation. Examiner Atural Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by zhiemms 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 pertormed certificate 1□ Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ Ne Certification: To this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

completely filled in by the funeral within 24 hours after death. To the Funeral Director: A

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a. Certifier

Medical

29c. License number D60888

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Krishnan Rakhi, M.D. P.O. Box 664 Leonardtown, MD

32. Registrar's Signature

M.D.

2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Day James Lewis Farmer 22 200 X /Medical Mare 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11308 Homestead Drive Big Pool Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 8, 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1X M 2□ F 76 Maryland Director 214-28-5463 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland Washington Big Pool 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11308 Homestead Drive 21711 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 No 195: If Yes, Give Year or Dates: 195: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item: edical Examiner n 1952-72 hours after 1 Never Married Married Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) 9 Machinist Automotive Part Manufacturer 1.2 should be filed w h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Payton Lee Farmer, Sr. <u>Cora Lee Graves</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June M. Farmer - Wife 11308 Homestead Dr. Big Pool, Maryland 21711 Saltimore, 20a. Method of Disposition

XXBurial 2 □Cremation 3 □Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Cedar Lawn Mem. Park Mar.27.2008 Hagerstown, Maryland nal me of Fungral Service Eicense Sporne furser faill Home, P.A. 425_S. Conococheague St.Williamsport.MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** manny /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed bunial-transit Exami Due to (or as a consequence of): Box 68760, attending physician for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.0. signed by the a 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury at Work? Division or Attending Natural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Earlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-5+1 OW NE 32. Registrar's Signature Year) 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Mark 2008 1851 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Universi timor n/a Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F 88 Director 160-10-4474 27, 1919 Pennsylvania Nov. Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? d other than "natural", or Items 23a or 2 event, the Medical Examiner must be n 21044 6336 Cedar Lane USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1938-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No \$ Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Industrial Mechanic Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 is marked ott Be injury or other traumatic George Factor Ida Goldberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if Item 27 is any injury or other trau James Factor/Son 833 Iron Rail Ct., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3-26-2008 Brookview Cemetery Rising Sun, Maryland 21. Sign are of uneral Service Licenses 22. Name and Address of Facility T. Foard Funeral Home, P.A. S. Queen Street, Rising Sun, MD 21911 ich ara Part . Enter the disease, or con shock, or heart failure. List only ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s that cau immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or s a consequence of): Examiner Hierann Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a correspuence of Examiner The law requires that the death certificate be executed ate and the burial-tran attending physician Physician/Medical use as i IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 9 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed Yes 2 No 1□ 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No funeral director Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t il or Attending Fafter death. 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the t 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Da

Division or Vital Records, P.O. Box 68760

HTIVA

State Registrar

Medical

MAUNG 31. Date filed (Month, Day, Year) MAR 2 4 2008

ADRIAN

29a. Certifier

(Check only one)

29b. Signature and title of confiner

and manner stated

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

b55500

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 8:00 AM ANNE F. GRIFFIN March 18 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 21,1915 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF 92 577-22-6943 Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10h County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1XYes 2 No Director Washington , DC 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5119 Nebraska Ave. NW 20008 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 'natural', or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medic I Examiner 1 ☐ Yes 2 X If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Woodward & Lothrop Sales Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest P. Harrison Betty Swetnam r 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5119 Nebraska Ave., NW Washington, D.C. 20008 Karen E. Griffin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/23/08 Cremation Center Chantilly, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1102 W. Broad St. Murphy Falls Church Funeral Home Falls Church, VA. 22046 auua 23a. Part 1. Enter the disease, or companies shock, or heart failure. List only ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 A No Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page performed' 2K No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 X Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation after death 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the

State Registra

29b. Signature and title of certifier

Year)

2008

2

31 Date filed (Month

DHMH 17 Rev 1/2001

2

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3/18/08

ORIGINAL Released my medical Examiner

29d. Date signed (Month, Day, Year)

March 18, 2008

29c. License number

8600 Old Georgetown Rd., Bethesda, MD.

completed cause of death (Item 23a) (Type, Print)

Pagistra

Signature

P.O. Box 68760, or Vital Records, Division

> State Registrar DHMH 17 Rev 1/2001

ewunmi gistrar's Signature

29d. Date signed (Month, Day, Year)

Prince

19,2008

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			State of Maryland / [ental Hygi	ene			
	60		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eath	2. Date of Death	g. No. 2008	3. Time of Death		
	Physici /Medic		WANDA CHRISTINE GOODMAN		Month 03			22 2008	2100 M		
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of Death			
	St. Communications Market No.	Į.	WMHS - BRADDOCK CAMPUS 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	CUMBERLA	Under 24 Hrs.	8. Date of Birth	ALLEGANY	place (State or Foreign		
	Funeral Director		4EIM OFFE	Yrs.	Months Days H	Hours Min.	(Month, Day, 12/16/1	Year) Cou	intry) nessee		
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Lo	eation				10d. Inside City Limits		
	Maryla f sho	tor			perland				1 □Yes 2 No		
	th the or 28a anotif	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	untry?		
	ath wi	ral	15821 McMullen Highway, Apt B-6		21502			US.			
326	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give		Vas Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2[X] No S	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:			
215-0036	hin 72 hou 3. In "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	ent's Usual Occupation kind of work done during O NOT use retired)	n ng most of workin	9g	6b. Kind of Business/I			
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and	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) Floyd Jo	ones		. Mother's Name May	(First, Middle, M.	,	evens		
ž	2 should and Mei is mark aumatic	잍	·					City or Town, State, Z			
₹.	and 2: ealth ai n 27 is ier trau		1		S. High St				404		
altimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		I I Duria: 2 Michemation 3 I nerrioval forti State 1		sition (Name of natory or other place)			Oc. Location - City or			
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n E	Depa Impo any i		Mene & adams	4	04 Decatur	Street	, Cumber	land, MD	21502		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequenc								
8/60,	cate be executed physician and the burial-transit	dical E	d	OI).							
O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year		
ras, P	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause given ir	n Part I.	23e. Did tob	acco use contribute to s 2x No 3 □ Pro	the cause of death?		
Hecords	a 5 €	Completed	Type It probetes wellten			**	24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of		
Ипа	Physician: this certific al director,	Be (25. Was case referred to medical examiner?			6. Place of Death					
0	Phys r this c ral dir	은	The Parison Parison 2 EH/Ou	utpatient Time of				nce 6 Other (Spec	ify)		
0	Attending r death. ector: After by the fune	ation	Natural 5 □ Pending (Month, Ďaý Year) I 2 □ Accident investigation	Injury	28c. Injury at Work? M 1 ☐ Yes	2 🗆 No		in injury occurred			
DIVISION	al or Atte s after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	ırm, stre	eet, factory, office	2	8f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	nd/or inv	estigation, în my opini	on, death occurre	ed at the time, da	ite and place, and due	to the cause(s)		
		Σ	29b. Signature and title of certifier		29c. License nu	Imber	29	d. Date signed (Month	, Day, Year)		
•	3		30. Name and address of person who completed gause of death (Item 23a) (/Type	D CO	18216		0/24/08			
	noss		Steven-R-Smith MD 900	S S	for Or	Cumber	land, M	0 20002	_		
	Sta Registr		31. Date filed (Month of 225 2008 32. Faistrar's Signature	B	29c. License nu Doo						

Hospital or Attending Physician: within 2

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 MUTORD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 2 6 2008



DHMH 17 Rev 1/2001

State

Registrar

of Print in Black Indelible link. Ensure All Copies Are Legible: State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Calvin Gobble March 22, 2008 12:50 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 22 Misty Meadows Drive Port Deposit Cecil If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months 67 212-38-4273 Yrs Aug. 17,1940 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Port Deposit Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 U.S.A. 22 Misty Meadows Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Elementary/Secondary (0-12) Eight Years College (1-4or 5+) Aberdeen, Maryland Warehouseman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Prevett Calvin J. Gobble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Misty Meadows Drive, Port Deposit, Maryland 21904 June B. Gobble (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 03/24/08 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign are of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner 3 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) detached 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No page 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 2 ER/Outpatient 3 DOA ို To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 🖾 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cent March 25, 2008 D0063981 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Lee, M.D., 669 Revolution Street, Havre de Grace, Maryland 37 Registrar's Signature 31. Date filed (Month, Day, Year) 2008 Registrar MAR 2 4

		1 - For State Registrar	· ·	artment of Health and N rtificate of Death	Reg. A	2000 10011
Physici /Medio	cal	Decedent's Name (First, Middle, Last) A acility Name (If not institution, give street a	ternandez-E		3 16	Day Year 3. Time of Death 945 P M
Examir	ner	College View Center 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Frederick If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederick 9. Birtholace (State or Foreign
Funeral Director		213-51-6445 Usual Residence of Decedent	64 113	Months Days Hours Min.	Dec. 28,	
he Maryia 8a-f ehow	ector	Md. 10b. County 10b. County Frederic	t Frederi	ck		10d. Inside City Limits ™ Yes 2 No
23a or 2	Funeral Director	10e. Street and Number 624 Bushytail Drive		10f. Zip Code 21703		Citizen of What Country? El Salvador
portition of a many factor of the 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or itema 23a or 28a-f ehow apprintury or other traumatic event, the Madical Examinar must be notified at ance.	þ	1 Never Married 2 Narried 1 If Y	Yes 2x No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		14. Race - American Indian, Black, White, etc. Specify: White
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nd 2 sho alth and 1 27 is mu		19a. Informant's Name/Relationship (Type, Pri Santiago R. A. Escol		ng Address <i>(Street and Number or Ru.</i> Bushyt ail Drive		y or Town, State, Zip Code) • Md • 21703
Pages 1 and of Hermont: If item		20a. Method of Disposition 1	i iiulii State	matory`or other place)		Location - City or Town, State El Salvador n Salvador
permit. Departrimports any inju		21. Signature of Funeral Service Lice see	con, CE36/ 3			nc. ington, <u>D.C. 20010</u>
the Hospital or Attending Physicien: The law requires that the death certificate be executed the Hospital or Attending Physicien: The law requires that the death certificate death. The Funeral Director: After this certificate has been signed by the attending physician and the properties of the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e on each line.	arterial d		Approximate Interval Between Onset and Death
ding Physicien: The law requires that the death certificate h. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
requires that	þ	Part II. Other significant conditions contribution END STORE RE	g to death but not resulting in the u		HD20	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
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ne Hosp n 24 hou ne Funei bietely fil	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, deat the basis of examination and/or in d manner stated.	th occurred at the time, date and place exesting ation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To the withing To the comp	W	29b. Signature and title of certifier	MS	29c. License number		Date signed (Month, Day, Year)
(3)		30. Name and address of person who complete	650 Thomas		Frederic	IL MD 21702
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature			

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State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

08-02144	Please Type or Print in Black Inde	Slible Ink. Ensure All Copie	riene	
Al Fletcher Hunter, Sr	State of Maryland / Departr	ment of Health and Mental Hy		nns ing7:
_	- Latina	icate of Death	Reg. No. £	3. Time of Death
Physician/	. Decedent's Name (First, Middle,Last)	•	Month Day Year March 16, 2008	1510 hrs
Medical Examiner	Al Fletcher Hunter, Sr.	4b. City, Town, or Location of Death		Death
£	a. Facility Name (if not institution, give street and number)		Prince Ge	L L
-	Prince George's Hospital	Cheverly	. 8. Date of Birth(MM/DD/YYYY)	9. Birthplace (State or
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	-	Foreign
	266-30-0563 1XM 2 F 79	Yrs.	07/19/1928	Country)Florida
	Usual Residence of Decedent			10d. Inside City Limits
1 1-	10a. State 10b. County 10c. City, To	wn or Location		1 X Yes 2 No
≱ .	DC Wash	ington, DC		
to to to	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
death with the Maryland or items 23a or 28a-f show must be notified at once.		20019	USA	
th the	4315 E Street, S.E. 11 Marital Status 12. Was Decedent Ever in U.S.	43 Was Decedent of Hispanic Origin? (S		- American Indian, Black,
or items 23	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	, 610.
or it	1 \times Yes \times 3 Widowed 4 Divorced If Yes, Give Year \times 4 \times 5 - 4 9	1 Yes 2 X No specify:	Specify:	Black
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5-0036 ed within 72 hours aftygiene. other than "natural" the Medical Examine Completed by	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumame)	
Hyg Hoth	Charles Hunter	Bertha	McNeal $__$	
21215-0036 uld be filed within 7 Mental Hygiene. nuarked other than nearest, the Medica	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Tow	n, State, Zip Code)
	Hattie King Hunter (Wife)	4315 E St., SE, Washi	ngton, DC 20019	
M 22 ann 27 ann	20b, Pl	ace of Disposition (Name of cemetery,	Date 20c. Location -	City or Town, State
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		ematory or other place) Intico Natl. Cemet. 03	/25/2008 Triang	le. VA
Page nent or oth	A Donation 5 Other Specify:	22. Name and Address of Facility	Latney's Funera	1 Home
alti mit. partu iport	21. Signature of Funeral Service Licensee	3831 Georgia Ave.	. NW. Washington	n,DC 20011
D 8 9 = 1	278 23a. Part I. Efter the disease, or complications that caused the death.	Do not enter the mode of dving, such as cardiac	or respiratory arrest, shock, or he	art Approximate Interval
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30, te be nysici	IF FEMALE: 23c. If yes, outcome of pregr	nancy	23d. Date of Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur hysician/Mec	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pre	gnancy	,
th cer truse	past 12 months? 4 Pregnant at time of de	ath 5 Other (Specify)		
box 68760, the death certificate be even to the attending physician the for use as the burial physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown	esulting in the underlying cause given in Part I.		tribute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death. with 124 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the burial confident of the funeral director, page 2 should be detached for use as the burial confident of the funeral director.		, ,	1 Yes 2 V No	3 Probably 4 Unknown
sign Sign 1 bed Ded b			24a. Was an 24b	. Were autopsy findings available
Records, 1 The law requires ficate has been signage 2 should be			autopsy performed?	prior to completion of cause of death?
e law le has			1 Yes 2 No	1 Yes 2 No
/ital Rec ysician: The l his certificate I director, page		26.Place of Death (Ch		
ital sician s certi	examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other, N	ursing Home 5 Residence 6	
Phys eral di	27 Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occi	urrea
n o n o n o n o n o n o n o n o n o n o	1 V Natural 5 Pending	1 Yes 2 No		-
Sio Atten deat of the	2 Accident Investigation 28e. Place of Injury - At r	nome, farm, street, factory, office building, etc.	28f. Location (Street and Nur or Town, State)	mber or Rural Route Number, City
Division of Vital Records, spital or Attending Physician: The law require towns after death. Filled in by the funeral director, page 2 should be contiled in by the funeral or ARP Completed	3 Suicide 6 Could not be determined (Specify)		C) Town, otato,	
Division of \ Division of \ To the Hospital or Attending Phy within 24 hours after death. To the Funcral Director: After the completely filled in by the funcral		dge, death occurred at the time, date and place	, and due to the cause(s) and man	ner as stated.
To the He within 24 To the Fu completed	Zea. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) 2 Medical Examiner: On the basis of examination:	and/or investigation, in my opinion, death occur	red at the time, date and place, an	d due to the cause(s)
within Com	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date s	igned (Month, Day, Year)
2	1	O.C.M.E.	March 1	7, 2008
11.	Juste yeg MD	m 23a)		
4	30. Name and address of person who completed cause of death (Itel Tasha Greenberg MD. Assistant Medical Exar	m 23a) miner 111 Penn Street, Baltimore	, MD 21201	
	Table 5			
Sta	WAT & I COUD KEEPERAL	ture of Ayerla		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar/AMEND#4bpenMD3/25/08,BMW,McCo Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** Lucy A. Hollis 2008 8:30 0.3 18 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Suburban Hospital Bethesda M.D.
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F 245-92-8348 N.C. 84 01/22/1924 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r 28a-f show notified at 1 →Yes 2 □ No Director M.D. Montgomery Bethesda 10f. Zip Code 20812 10e. Street and Number 5721 Grosvenor Lane 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant if Item 27 is marked other than "naturar", or Items 23a or any or other traumatic event, the Medical Examiner must be urry or other traumatic event, the Medical Examiner must be U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 t Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Grimes Maggie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanie M. Crockett-Daughter 3 Travis Ct. Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot East Lawn Memorial 03/23/2008 Tarboro, N.C. 1 Ma Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility The House of Williams Funeral Service- 814 Upshur St. NW WDC Willeries 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? ned by the at detached for 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ ✓ o 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy HoLLIS, LUCY A. 1 ☐ Yes 2 🗘 No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/18/08 Zes, MD 00057124

State Registrar

32. Pagistrar's Signature

BAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
I - UCNG DAD M.D. 9715 MedicAL CENTER DR S 201 ROCKVILLE, MD. 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 12:15 a M Frederick S. Hodgson March 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adventist Health Care Sligo Creek Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**⊠**M 2□F Bermuda Director 120-46-6701 78 December 4, 1929 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 □Yes 2 KINo Director Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 8206 15th Place 20783 Bermuda death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: <u>^</u> 3 ☐ Widowed 4 ☐ Divorced B1ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F æ Frederick William Hodgson Olga Wallena Trott ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Evelyn Hodgson - Spouse 8206 15th Place, Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/26/2008 Lincoln Memorial Park Suitland, Maryland d 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Prostate Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \omega Nursing Home 5 \omega Residence 6 \omega Other (Specify) Hospital: 1 Yes 2x No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of cortifle

Yeheyis Negussie, M.D., 31. Date filed (Month, Day, Year) MAR 20 2008

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1111 Spring Street, Suite 214, Silver Spring, Maryland 20910

D45471

29d. Date signed (Month, Day, Year)

March 18, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

			State		artment of Health and M			
			1 - State Registrer	•	rtificate of Death	Reg. f	2000	10976
	<u> </u>		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medio Examin	cal	William Ralph Horner 4a. Facility Name (If not institution, give street and no	imber)	4b. City, Town, or Location of Death	March 1	•	4:45 A ^M
			Ravenwood Lutheran Vil		Hagerstown		Washington	1
	Funeral Director		5. Social Security Number 6. Sex 12 M 2 □ F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		lace (State or Foreign stry)
	ס		Usual Residence of Decedent	07		Sept.30,19	920 Penns	ylvania
	arylan show	-	10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits 1 X Yes 2 □ No
	Ne Mi	ecto	Maryland Washington		Hagerstown			
	with with the same or 3	Funeral Director	10e. Street and Number 504 Brown Avenue		10f. Zip Code 21740	10g. e	Citizen of What Cour	itry?
	ms 23	era	11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or items 23a or 28a-f show emportant: If item 27 is marked other than "neturel; or items 23a or 28a-f show empiriquity or other traumatic event, Ite Maralcal Examiliar institle multiplications.	by	1 X Never Married 2 Married 1 X Yes, G 3 Widowed 4 Divorced Year or I	2□No WWII	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: W	_{hite}
5	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed,	(Give	dent's Usual Occupation kind of work done during most of work	ing 16b.	Kind of Business/Inc	dustry
121	within ne. han	mpl	Elementary/Secondary (0-12) College	1-4or 5+)	DO NOT use retired)			
Q Q	filed v Hygie ther f		12 1 17. Father's Name (First, Middle, Last)		Book Keeper 18. Mother's Name	(First, Middle, Maid	Retail	
lan	id be entai ked o	To Be	William Ralph Horner, S	Sr.				
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rura	egina Hun al Route Number, City		Code)
Σ	and 2 salth a n 27 li		Alma K. Rockwell - Person	nal Rep. 2237	Vineyard Road Fall	ing Water	s. WV 25	010
Baltimore,	ges 1 t of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, crer	Vineyard Road Fall sition (Name of matery or other place)	ate 20c.	Location - City or To	wn, State
Ħ	t. Pag tmen tant: jury		` 4 □ Donation 5 □ Other (Specify)	Smithsbur	g Crematory Mar.19		thsburg,	Mary Land
Bal	permi Depa Impo eny ir		21. Signatur of Funeral Service Liberture		P berne d निपामक्षित्रने विभाग्निमाण 15 S. Conococheague			WD 2170E
			23a. Part . Enter the disease, or complications that	caused the death. Do not ent			Tamsport,	Approximate
	Physician /Medical		shock, or hear failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. 1900 M D M I (or as a consequence of):	A			Interval Between Onset and Death
	physician and physician and sthe burial-transit	cal Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):	ACT INFEC-	710M		
			d					
P.O. Box (The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
ds, P.	w requires that been signed bi should be deta	by	Part II. Other significant conditions contributing to a	_	, ,		o use contribute to th	
Vital Records,	The taw recate has bee page 2 shor	Completed	PRUSTATE CAT	cap		24a. Was an autopsy performed	prior to cor death?	csy findings available inpletion of cause of
ita		Be C	25. Was case referred to medical examiner?		26. Place of Death		10 103	2
	Attending Physicien: or death. ector: After this certifically the funeral director.	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐	Inpatient 2 ER/Outpatien	nt 3 DOA Other: Nursing Ho	me 5 ☐ Residence	6 ☐Other (Specify	')
D C	ding P	lon:	1 aldid	of Injury 28b. Time of hth, Day Year) Injury	Work?	28d. Describe how in	jury occurred	
Division of	ttend death stor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be	e of Injury - At home, farm, str	M 1 Yes 2 No	28f. Location (Street	and Number or Pure	I Pouto Number
<u>></u>	after death after death Director: Jin by the	Certification:	4 Homicide determined build	ing, etc. (Specify)	eet, factory, office	City or Town, Sta		r Adale Namber,
	To the Hospitel or Attending Physicien: within 24 hours after deals within 25 hours after deals to the Funeral Director. After this certific completely filled in by the funeral director.	edical C	(Check only 2 Medical Examiner: On the b	e best of my knowledge, death pasis of examination and/or invener stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, I	Day, Year)
			· UV		000623	113	118/08	
51	45+1		30. Name and address of person who completed cau		Print) Rina Bansal, - EKTVWM,	M.D.	21740)
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4 2008 32. F	strar's Signature	E. D.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician MAK 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner teninsulas Regional Madirol Salisbura NICOMICO 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**№**M 2□ F Director -48-1209 9-30-1930 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director lincoteaque Hccomack 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2333 S 6281 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Iten any Injury or other traumatic event, the Medical Examines and. 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married and 21215-0036 1 ☐ Yes 2 ☑No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Janstor Hccomack County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Bloxem Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2333L hincotcague UA a3331

Date 20c. Location - City or Town, State Frances Hudson Church 281 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 Cremation 3 Removal from State 3-22-2008 4 □ Donation 5 □ Other (Specify) Oak Hall, UA Cemetery 21. Signature of Funeral Service Licensee 2. Name and Address of Facility VA 23336 amanda Salver Funeral Chincotcoque 6327 Church St Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OPD **Physician** /Medical Due to (or as a consequence of): Examiner 484B Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I 2 No 1□ Yes Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 170 30. Name address of person who completed cause of death (Item 23a) (Type, Print) Michael 100 E. Feld 32. Registrar's Signature 31. Date filed (Month, State 1 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and M Certificate of Death		jiene leg. No. 200	8 10978
	- W/		Decedent's Name (First, Middle, Last)	2. Date of Dea	th	3. Time of Death
	Physicia /Medic		Mary Dell Johnson	Month March 1	Day Ye	8:36 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of [
	4	£	Southern Maryland Hospital Clinton		Prince	George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 / 26 22 23 3 4 1	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
44 2	Director		Usual Residence of Decedent	Jan 19,	1933 V:	irginia
1	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
-	Mary Fied a	to	District of Columbia Washington			1 TYes 2 □ No
4	in the)irec	10e. Street and Number 10f. Zip Code	1	10g. Citizen of Wha	t Country?
	th will	al	2913 M Street, SE 20019		United S	
1	r dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
၀	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐		Specify:	Black
2-003p	hour Itural	ed b	15 Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busin	
Ç :	in 72 n "na n "na Medic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	ring		
717	d with giene rr tha the l	E O	12 years Food Service Worker		Priva	ite
ם י	al Hygen of the vent,	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Maiden Surname)	
yland	ould by Ment arked arked atic e	은		a White		
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If them 271s marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rur 10607 Timberline Dr. U			
e '	1 and Health			Date Ta	20c. Location - City	
פַ ו	ages nt of l		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20 200	·	
saitimore,	uit. Pa antme ontam Injury		4 Donation 5 Other (Specify) 21. Simulature of Funer V Service Line 1.2. Name and Address of Facility St			
ğ	Depo Impo any		4001 Benning Road			
	5 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):			
•	Examiner		Sequentially list conditions, b.			
22	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			1
	xecut and al-tran	xan	that initiated events resulting in death) Last C			
09/8	ficate be executed physician and s the burial-transit	dical E	d			
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X POX	th cert endin	M/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date o	
n :	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
7 5	nat the d by th etach	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	phacco use contribu	te to the cause of death?
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			Mutabali acidalis 25. Was case referred to medical 26. Place of Deat	1∏ Yes	2 No 1 L	Yes 2 M No
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DIVISION	I or Attendi after death. I Director: A d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number o vn, State)	or Rural Route Number,
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:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; t	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (f	
}	10		D43446		3.15.	08
	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	C.1 -	4. 1 100	
	BC		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reform FARAHIFAR M.D. 980) Geo Jin Ari Smit 3-41)ilver sy	my 50	20902
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 9 2008 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fb / 878 4-4-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nq. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day 22 2008 **Physician** Walter Lee Jones, Sr. 10:05 PM March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year July 09,1946 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs 215-44-9686 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Director Allegany Little Orleans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 11301 Appel RD S.E. 21766 Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed ed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Hauling 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Jones, Sr. ပ Mildred Elizabeth Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Jones/wife 11301 Appel RD, S.E. Little Orleans, MD 21766 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-27-08 Smithsburg Crematory Smithsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 141 West Main Street MO14/4 Grove Funeral Home, P., A. Hancock, MD 21750-0368 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sided disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HARSAMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit MICHUSIS Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the SB attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No Obs McXV 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident nin 24 hours after death the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-0056413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

MD

32. Paistrar's Signature

Court Hage stown, MD 21740

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year March 13, 2008 **Physician** Eleanor Cecelia Jehle 12:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) July 8, 19 Birthplace (State or Foreign Country) 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. Indiana 342-26-6802 75 1932 Director Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at West 1 ☐ Yes 2 No Director Ranson Virginia Jefferson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or a limpertant: If item 27 is marked other than "natural", or items 23a or a limper in it 551 Lone Oak Road 25438 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 🛣 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Joseph Jehle Dorothy Elvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Kelly/Daughter 4710 Guilford Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 15. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or low shock, or heart failure. List only Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Septic Shock /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ischemic Necrosis of Eowel Due to (or as a consequence of): Examine Closed Loop Abcess
Due to (or as a consequence of): burial-tran physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Dav 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ

Division or Vital Records, P.O. Box 68760 pe should page 2 s has certificate To the Hospital or Attending Physician: funeral director. after death filled in by the

Completed

Be

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Certification:

Medical

29a. Certifier

25. Was case referred to medical examiner?

31. Date filed (Month, Pay, Year)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Alzheimer's Dementia 24a. Was an autopsy performed?

2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Hospital: 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

and manner stated.

28d. Describe how injury occurred

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

2008

29c. License number 1460421010 AV 29d. Date signed (Month, Day, Year) March 19, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joanne F. Johnston, MD

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8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar

124 hours a

within 2.

State of Maryland / Department of Health and Mental Hygiene 1- Sathend #5 Per FH G878 4/21/08 Jh Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death Physician Year 038AM Goldie Joyce 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5217^{1.5}50¹¹9569 **Funeral** Months 1 M 2 F 218-03-6915 Director 82 23 1925 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or than "netural", or items 23a or 28a-f show the Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1135 Madison St. 21403 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: Black 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 Domestic Private Family item 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Smith Eleanor Sellman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Mable E. Johnson(Daughter) 1135 Madison St. Annapolis, Md. 21403 20a. Method of Disposition 20b; Place of Disposition (Name of Cemelery Elematory or other place) 20c. Location - City or Town, State Department of H importent: If ite any injury or of once. 1

Burial 2 □ Cremation 3 □ Removal from State 3-20-08 Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. WIN ame Reaches of & cilions Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Larry B, Jeese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A Spiration

Due to (of as a consequence of): Preumonia **Physician** /Medical Examiner rogressive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien end the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signification Cancer 1 🗌 Yes 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1□ Yes 2⊡No or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Tes 2 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun Natural 2 Accident investigation М 1 Tes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

A and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 056511 death (Item 23a) (Type, Print) rkway Annapolis 31. Date filed (Month, Day, Year) MAR 2 0 2008 State Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No ... 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 05 A M **Physician** Year Thelma NMN JONES March 22, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 904 Chestnut Street Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 80 255-34-2200 Director Dec. 3, 1927 Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Washington Hagerstown 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 904 Chestnut Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than environmental services hospital 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank (unknown) Johnson Viola (unknown) Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Efrem Jones - son 904 Chestnut Street, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 28. 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Sunset Hill Cemetery 2008 4 Donation 5 Dother (Specify) Valdosta, Georgia 22. Name and Address of Facility 21. Signature of Funeral Service License Minnich Funeral Home sucy 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Conce Due to (or as a consequence of): munto disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of it jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending phone IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy performed? certificate 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Certification: To After this eral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milormack redied Courses Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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MAR 24

2008

Amended #25, 27 nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 03/25/08, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1 - State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 03 Day 24 **Physician** Kro11 0640 Doris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **Allegany** WMHS Braddock Campus Cumber land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F August 29, 1921 Maryland 86 Director 213-18-2111 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Allegany Frostburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16617 National Highway, S.W. "natural", or items 23a or 21532-U.S.A. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Baltimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 □ Divorced White Year or Dates Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) sell cement products unknown 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie McFarland John W. Rephann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21532-16617 National Highway, S.W Frostburg Flovd Kroll 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 27, 2008 **Eckhart Eckhart Cemetery** 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 elin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 8 hRS >e /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of has autopsy performed death? 1 ☐ Yes After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 200 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Hospital or Attending 24 hours after death. Natural 2X Accident 5 Pending investigation PATIENI 2 X No 1 🗌 Yes E Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ROSTBURG, MD 21532 To the Hospital of within 24 hours at To the Funeral D **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify March 24, MR8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland Maryland 912 3 Seton Drive

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) (MAR 2 5 2008

Registrar
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32. Registrar's Signature

		Please Type or Prin						
		For State of Ma	-	epartment of I		Mental Hyg	giene	
Sauce Control		Registrar 1. Decedent's Name (First, Middle, Last)	C	Certificate of	Death	2. Date of Dea	th 200	3. Time of Death
Physici		Gloria Jean Keller	^				20, 2008	8:30A M
/Medi Examir		4a. Facility Name (If not institution, give street and number)	-	4b. City, Town, o	or Location of Death	4	4c. County of Dea	
		2340 Station Rd.		M	iddletov	vn	Fr	ederick
Funeral		5. Social Security Number 6. Sex 7. Age 217-42-8926 1□M 21 82	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec • 1	3, 1925 9. Bi	thplace (State or Foreign ountry) MD
Director		Usual Residence of Decedent	<u> </u>	5.		Dec. I	3, 1943	MD
yland now at		10a. State 10b. County	10c. City, Town o					10d. Inside City Limits
e Mar Ba-f sl	Director	MD Frederick		Middl	etown			1 ☐ Yes 2X No
with th	Dire	10e. Street and Number 2340 Station Rd.		10f. Zip Code	21769		10g. Citizen of What C US	
eath v	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S.			pecify Yes or No-		
after d		Armed Forces?	0	13. Was Decedent of I		Rican, etc.)		
ours a	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No				White
"natu	lete	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of wor	king	16b. Kind of Business	:/Industry
withir iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+	.)	afeteria	•		public	schools
e filed Il Hyg other	Be C	17. Father's Name (First, Middle, Last)					Maiden Surname)	
Menta Menta arked atic e	ToE	Joseph Fink			Bessi	le Long		
c, Inial yially 212.12.13.0000		19a. Informant's Name/Relationship (Type. Print) Lois Todd (Daughter)					r, City or Town, State,	. ,
1 and 1 and Health em 27 ther t		20a. Method of Disposition				Date	town, MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XBuria) 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify)		isposition (Name of crematory or other plamed ceme		22/08	Middleto	
mit. F partm portar / Injur		21 Signature of Funeral Service Licensee					neral Ho	
permi Depa Impo any Ir	(Inted Though	V	P U BOX	10 M10	Idletom	\mathbf{n} MD \mathbf{Z}	16 1769
		23a. Part1. Enter the disease, or complications that saysed shock, or heart failure. List only one cause on each line	the death. Do not	t enter the mode of dyl	ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	neumo					Oriset and Beatt
Examiner		Due to (or as a	consequence of)	:				
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scuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						
be exection a		Due to (or as a	consequence of)	:				
Attending Physician: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edica	d						
n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome programs and the program of the progr		оПс			23d. Date of de	elivery
death	Physician/M	in the past 12 months?		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _			Month	Day Year
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signe d be d	by	Part II. Other significant conditions contributing to death but Alzhiemer's Demen		te underlying cause gr	veiriir Faiti.			robably 4 Unknown
w require been sig should b	Completed					24a. Was a		autopsy findings available
The lay	ошо					autop perfor	sy prior to med? death?	completion of cause of
lan: 1	Be Co	25. Was case referred to medical			26. Place of Dea	1 Yes th (Check only or	2 K No 1 ☐ Ye	s 2□No
hysic his ce	To E		t 2 ☐ ER/Outpa	atient 3 DOA		ome 5 Resid	ence 6 □Other (Sp	ecify)
ding Physician: The lavan. After this certificate has funeral director, page 2	ion:	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day)	/ 28b. Tin Year) lnju	ury Wo		28d. Describe h	ow injury occurred	
death ctor:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury	y - At home, farm	, street, factory, office	Yes 2 □ No	28f. Location (S	treet and Number or F	Rural Route Number.
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification:	4 ☐ Homicide determined building, etc.	(Specify)			City or Tow		,
lospita hours unera		29a. Certifier (Check only (C	f my knowledge, o	death occurred at the t	ime, date and place	, and due to the o	cause(s) and manner a	as stated.
the H hin 24 the F mplete	Medical	one) and manner stat	ed.	29c. Licen				
Mit Vit		29b. Signature and title of certifier			58726	-	29d. Date signed <i>(Mor</i>	
5		30. Name and address of person who completed cause of de	ath (Item 23a) (Tv					
J		Yve He M. Lopez-Warren	mo	3000 - D	Ventrie (Ct. Mye	evsuille ma	21773
Sta		30. Name and address of person who completed cause of de Yve He M. Lopez-Warren 31. Date filed (Month, Day, Year) MAR 2 4 2008	s Signature	K South				
Regist	'al'	MULII # 7 2000		7				

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			_ For	State of M	arylan	d / Depa	rtment of F	lealth and l	Mental Hy	giene	ogibio.	
			1 - State Registrar			Cer	tificate of	Death		Reg. No.	2008	10986
	Physicia	an	1. Decedent's Name (First, Middle, La		C .				2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	Porter Kr			4b. City, Town, or	Location of Deatl	March	24,	2008 County of Deat	8:30 A M
	EXAMIN	le i	27270 Willin Lan				Federa	lsburg			Caroli	ne
	Funeral		5. Social Security Number 6. S			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birt	hplace (State or Foreign untry)
, 1636 no	Director	}	220-74-2968 Usual Residence of Decedent	X-1W 2-1	5() Yrs.			Septembe	r 13,	1957 Ma	ryland
yland	at		10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
e Mar	3a-f sh tiffied	ctor	Maryland Caroli	ne	Fee	deralst	ourg					1 ☐ Yes 2 ☐ No
with th	a or 28 be no	Funeral Director	10e. Street and Number				10f. Zip Code				en of What Co	
eath	ns 23a must	eral	27270 Willin Lane	12. Was Decedent	Ever in U.	s. 13. W	21632 /as Decedent of H	ispanic Origin? (S			d State 4. Race - Ame	es of America rican Indian,
after d	or iten niner		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2- If Yes, Give	?			ispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)		Black, White	e, etc.
ing Z IZ I 3-0030 be filed within 72 hours after death with the Maryland	ural", d I Exar	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			☐ Yes 2☐xNo					casian
n 72 h	"nati edica	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	Ų.	(Give k	ent's Usual Occup kind of work done O NOT use retired	during most of wor	rking	16b. Kin	d of Business/	Industry
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ar yra	Ment narked natic e	2	William		Kraf	-			e Marie		-	
and 2 sh	Health and Mental Hygiene. em 27 is marked other than other traumatic event, the Me		19a. Informant's Name/Relationship (Jessica Kraft	Daught	er			and Number or Ru . Avenue,				21660
s ar	item item		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of	- 1	Date		ation - City or	
Page	ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specit</i>	JRemoval from State y)			Cremator	i i	/2008	Dove	r, Dela	aware
Dall bermit.	Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	Moor_		Mc	Name and Addre	eral Home	, P.A.			
			23a. Part1. Enter the disease, or com	plications that cause	d the death						. Mary	Approximate Interval Between
DH	ysician		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ine.	0 0	la h	Carro	,			Onset and Death
- 1	Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	uence of):		Cook				lyr 3mo
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ted	nsit	Examiner	Sequentially list conditions, if any leading to him districtions. Enter Underlying Cause (Disease or injury	Due to (or as	a conse	dence ori:						
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The law requires that the death certificate	igned be de	þ	Part II. Other significant conditions	ontributing to death t	out not resu	ulting in the un	derlying cause giv	en in Part I.		tobacco us Yes 2□		the cause of death?
requires 1	speen s	eted	,									
he lay	2 23	Completed								psy ormed?_	prior to death?	itopsy findings available completion of cause of
an:	rtificat tor, pa	a)	25. Was case referred to medical					26. Place of Dea	1 Yes ath (Check only	2 ☑ No one)	1 ∐ Yes	2□ No
hysici	his ce I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		ER/Outpatient	3 DOA Oth	er: 4 ☐ Nursing F	lome 5 ☐ Res	idence 6	□Other (Spe	cify)
d guit	After I	ion:	27. Mann of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injur Wor M 1 □	y at k? Yes 2 □ No	28d. Describe	how injury	occurred	
Attend	r death	ficat	3 Suicide 6 Could not b	e 28e. Place of in	jury - At ho	me, farm, stre	et, factory, office	100 2 110			Number or Ri	ural Route Number,
2 p	s after al Dire ed in t	Certification:	4 ☐ Homicide determined	building, e	tc. (Specin	<i>(</i>)			City or 10	wn, State)		
Hospi	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Gertifying Pt (Check only one) 2 Medical Exal	nysician: To the best miner: On the basis of	of examina	wledge, death tion and/or inv	occurred at the tirestigation, in my o	me, date and place ppinion, death occ	e, and due to the urred at the time	cause(s) a , date and	and manner as place, and due	s stated. e to the cause(s)
o the	ithin 2 o the omple	Med	29b. Signature and title of certifier	and mapher st	iated.		29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
_	> - 0		· VIX	7			D2	5887		31	24/0	8
			30. Name and address of person who					3.6		2160	1	
	Sta	to	David H. Smith, 31. Date filed (Month, Day, Year)	M.D., 2946			Drive, Ea	aston, Ma	ryland	2160	1	
	Registr		MAR 2 6 200	62	· 19	An	52.6					

DHMH 17 Rev 1/2001

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amend item 19a per inf 2878 4-9-08 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 21, 2008 6:10 P M Doris Clark Kehs March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Homewood Retirement Center Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🗙 F Director 95 5, 144-40-8321 Dec. 1912 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 4301 Banff Springs Court 20853 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: White 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Henry Clark Melissa Amelia Metzger 19a. Informant's Name/Relationship (Type. Print)
Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia M. Daly Daughter Banff Springs Court Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Important: If any Injury or one. Maplewood Cemetery 04-01-2008 Freehold, New Jersey 22 Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that auser the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** WELMON (/Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Z Elmen 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has irector, page 2 autopsy performe Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ပ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mapner of Death eral Director; After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signate DICOA Attra Who completed cause of death ? mo V3H-15

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Yea

MAR 24 2008

32. Registrar's Signature

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Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
/Media		MILDRED	М.	KITCHENS			MARCH	19 2008	7:15 A
Examir	er	4a. Facility Name (If not institution, give s ATLANTIC GENERAL			1	, or Location of Death		4c. County of Deat	
r		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Yea	LIN ar If Under 24 Hrs.	8. Date of Birth	WORCEST	
Funeral Director			M 2XF	84 Yrs.	Months Day		SEPT . 29	(ear) Co	hplace (State or Foreig untry) LLAWARE
		Usual Residence of Decedent					DELI. ZZ	, 1723 DI	LAWAKE
neam with the Maryland ms 23a or 28a-f show	<u>_</u>	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
28a-f ehor	Directo	MARYLAND WORCEST	ER	BISHO					1 ☐ Yes 2X N
N or 2		10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
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naturel', or items ilcal Exactinar in	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 N	0	If Yes, specify Cu	f Hispanic Origin? (Sp uban, Mexican, Puerto	Rican, etc.)	Black, White	
	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2XIN	o Specify:		Specify: W	HITE
"naturel".	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occ	upation	16	b. Kind of Business/	Industry
- 25	npfe	Elementary/Secondary (0-12)	College (1-4or 5-	-)		ne during most of work red)	g		
d other then	S	12		HC	MEMAKER			OWN HOM	IE
Mental F arked of atic ever	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
th and Mental Hygiene. 7 is marked other then treumatic event, it a M	၉	HUGH 19a. Informant's Name/Relationship (Ty)	STEPHENS	10b Mailie	na Addrana /Ctra		ENCE	MUMFO	
7 is		EARL L. KITCHENS/S				et and Number or Run			
He He		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	ST., BISHO		c. Location - City or	
Department of Importent: If it any injury or once.		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		natory or other p	1			
ortan injur		21. Signatur 21 Funeral Service Library	()		LLE CEME Name and Add	TERY 3/22	2/08 BI	SHOPVILLE	, MARYLAND
Pep and pep		1 (Laste W2	with			FUNERAL HO	ME, SELBY	VILLE, DE	. 19975
		23a. Pert1 Enter the disease, or compli- shock, or heart failure. List only on	cations that paused	the death. Do not ent					Approximate
sician		Immediate Cause (Final disease or condition	ASO	coting 1	001	menic			Interval Between Onset and Death
edical		resulting in death)	Due to (brasa	consequence of):	-1/110	umenia			
niner		Samueliativ list a writting			/				
Ħ	iner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence of):					
and I-trans	Examine	that initiated events resulting in death) Last		consequence of):					
5 7	ical E		DUB (0) (0) 25 2	consequence or):					
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nding use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome o	f pregnancy				23d. Date of deli	1907
a attending phy d for use as th	iciar	in the past 12 months? 1 Yes 2 No	1□Live birth 2 4□Pregnant at t		Ectopic pregnant Other (specify)	су		Month	Day Year
ed by the detached	hys	9 Unknown	9□ Unknown						
should be det	oy P	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause o	pven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
g pluc	ed i						1 ☐ Yes	2No 3□Pro	obably 4 ∐Unknov
5 CA	Completed						24a. Was an	24b. Were au	topsy findings availab completion of cause of
page	Ë						autopsy performed	d? death?	2 No
is certificete director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	h (Check only one)		
<u>∞ =</u>	2	1 ☐ Yes 2 No	ospital: Inpatien	t 2 ER/Outpatien	t 3 DOA	ther: 4 🗆 Nursing Ho	me 5 Residenc	e 6 □Other (Spec	elfy)
ner l	ü	27. Manner of Death 1 Matural 5 ☐ Pending	28a. at of Injury (Month, Day	Year) 28b. Time of Injury	W	ork?	28d. Describe how	injury occurred	
후	cat	2 Accident investigation 3 Suicide 6 Could not be	on Bloomflein			☐Yes 2☐No	201 1 11 10		
ē ģ	Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm, stre (Specify)	eet, factory, offici	9	City or Town, S	et and Number or Ru State)	ral Route Number,
filled	Ö	29a. Certifier 1 Certifying Phys	cian: To the best of	my knowledge, death	occurred at the	time date and place	and due to the cause	20(0) and magner on	etatod
e Fur	edicai	(Check only 2 Medical Examinone)	er: On the basis of a	examination and/or inv	estigation, in my	opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	Me	29b. Signature and title of certifier	(I)		29c. Licer	nse number	29d.	. Date signed (Month	, Dey, Year)
To the		•	olt	M	(i)	11585	Ma	rch 19, 2	800
Toth		,	MI L	. 4	1 1 /1	11 -1 -1 1 -			
within 24 hours after death. To the Funeral Director: Algorithm of the funeral plined in by the funeral pline in the funeral pline funeral pline funeral pline funeral pline funeral pline funeral pline funeral pline fun		30. Name and address of person who con	meleticause of dea	ath (Item 28a) (Type,	Pfint)	09-00	01	mo	2101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death) Day Month 3 Year John William Keeley 1310 9 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale Baltimore FRANKLIN SQUARE HOSPITAL Center 8. Date of Birth
(Month, Day, Year)
Sept. 20, 1937 If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 1⊠M 2□F 184-30-1081 70 Sept. Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Ves 2 No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 Frenchtown Road 21903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Edgemoor Materials Elementary/Secondary (0-12) College (1-4or 5+) Mechanic & Fleet Manager Twelve Years North East, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Keeley Ida Mae Hyde 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean D. Keeley (wife) 1009 Frenctown Road, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 03/22/08 4 ☐ Donation 5 ☐ Other (Specify) West Chester, Pennsylvania 21. Signature of Funeral Service License 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bacterial Fungal bac Due to (or as a confequence of): b. Fungal Pn. pheumonia Sequentially list conditions any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Neutropenia
Due to (or as a consequence of): brain CA Small Cell Lung cancer with Larynaeal metagasis IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation Gerd bladder 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No

Examiner The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending physician the as use à page 2 or Attending Physician: this funeral

After

Director: filled in by

within 24 hours a

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

ral", or items 23a or Examiner must be r

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other

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permit. Page Department of Important: If any injury or

Physician

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Completed

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Examiner

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Completed

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death with the Maryland

filed within 72 hours after

21215-0036

Maryland

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Pages 1 ŧ = 5

> 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

മ്	examiner?	26. Place of De	eath (Check only one)
10	1 Yes 2 No	Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
ication:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
dical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	ysician: To the best of my knowledge, death occurred at the time, date and plan niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

DR

Ballo

29d. Date signed (Month, Day, Year)

21237

Park

ZUUB

RES 0000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311912008

md

State Registrar

Hang K 31. Date filed (Month, Day, Year)

32. Registrar's Signature

9000 FRANKLIN Square

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03 08 1100 M Leatherman 21 Lewis /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WMHS Braddock Campus Allegany Cumber land | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | DEC • 22,1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**∏**M 2□F WEST VIRGINIA 72 236-50-0647 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County WV FORT ASHBY MINERAL 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26719 U.S.A. ROUTE 46 WEST Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MILLWRIGHT LOCAL 1024 MILLWRIGHT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES LEWIS LEATHERMAN VIRGINIA LEE MESSICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 224, FORT ASHBY, WV 26719 SHARON LEATHERMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FORT ASHBY CEMETERY 03/24/2008 FORT ASHBY, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility UPCHURCH FUNERAL HOME, INC. penunch P.O. BOX 1260, FORT ASHBY, WV 26719 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conservence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an 2 No 1□ Yes 28 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 3□ DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification:

certificate be executed burial-tran physician the as attending p the detached ģ

> page 2 s certificate has

After

To the Funeral Director:

Medical

24 hours after

Hospital or Attending

To the

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 Is marked other any Injury or other traumatic event, tt

Physician /Medical Examiner

within 72 hours after death

Maryland 21215-0036

Baltimore,

Box 68760

o

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Records,

Division or Vital

5 ☐ Pending investigation

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

1 Natural 2 Accident

3☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier Nomocketh

6 ☐ Could not be

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1 ☐ Yes 2 ☐ No

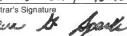
2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BISHOP WALSH RD CLIMBERLAND, MD 2150 SHIN

State Registrar 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05/3M more anca 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 091 0/ Mont (sem . A & 20mex 8. Date of Birth (Month, Day, Year) NOV.11,1988 If Under 1 Year | If Under 24 Hrs. 5. Social Security Yumber 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □XM 2 □ F 212-23-5983 Maryland Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits a or 28a-f sh 1 ☐ Yes 2 X No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r 14517 Dunsinane Terrace 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Mitchell Lucie Lancaster P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14517 Dunsinane Ter.Silver Spring,MD 20906 Lucie Lancaster (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Pk Crem 3/24/08 Riverdale, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signa we of Funeral Service Lic 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not ynter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 1210 resulting in death) /Medical Due to (T) s a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 1 🔲 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 Natural MGT 14 2006 1 🗌 Yes 0400 M 2 Accident Loc III n (Sheet and Number of Rura City or Town, State) 1451 6 ☐ Could not be 3 Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 7 Owindne Lome Jerr mn 20906 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and anner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and see to the cause(s) and mapfiel stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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cause of death (Item 23a) (Type, Print)

WEX

32. Raistrar's Signature

		For State	State o	of Marylan		artment of H <i>rtificate of L</i>			000	30 10002	
ton in	-	Registrar 1. Decedent's Name (First, Middle, I	astl		Cer	lilicale of i	Jean	2. Date of Dea	Reg. No. Z	3. Time of Death	
Physic		Julia Pavick La						Month		0021 M	
/Med Exami		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town, or	Location of Dea		4c. County of		
		Anne Arundel Me	dical Ce	nter			polis		Anne A	runde1	
Funeral Director		5. Social Security Number 6 553-66-5150	Sex 1 □ M 2√2 F	7. Age (In yrs. 6		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1943	Birthplace (State or Foreign Country) NY	
pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation				10d. Inside City Limits	
lanyla shot	ò		A 1 . 1			cation				1 ☐ Yes 2X No	
the N 28a-f notifie	Director	MD Anne .	Arunde1	4	Arno1d	10f. Zip Code			10g. Citizen of Wha	at Country?	
with sa or	Ö	1396 Baltimore	Annanoli	e Blad		210	12		US		
death ms 2:	Funeral	11. Marital Status		edent Ever in U. prces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No-		American Indian,	
or ite	Ē	1 ☐ Never Married 2 ☐ Married		2000NO		t Yes, specity Cuba 1 □ Yes 2002 No	n, Mexican, Pue Specify:	rto Hican, etc.)		White, etc. White	
ified within 72 hours after death with the Maryland Hygiene. Thypiene. The Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:				Specify:	WILLEC		
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withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)						Store	
Hygi Hygi	ပ္	17. Father's Name (First, Middle, La	st)		I	18. Mother's Name (First, Middle, Maiden Surname)					
Ild be fental rked c	To Be	John Pavick					Nancy	Barton			
and N		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numbe	r, City or Town, Sta	ate, Zip Code)	
and 2 ealth n 27 i		Julia Gardner	Daugh			Grant St.	Annaj	olis, MD			
ges 1 t of H if iter		20a. Method of Disposition 1 Burial 2XXCremation 3	☐Removal from	State	emetery, crer	sition (Name of matory or other plac		Date	20c. Location - Cit		
t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Spe		Me		ematory			Baltimor		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur of Funeral Service Li	encee -			. Name and Addres	110			ome, P.A.	
- 3 - 22		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that	caused the deatl		Ridgely er the mode of dyin			MD 2140	Approximate Interval Between	
Physician		Immediate Cause (Final				1				Onset and Death	
/Medical		disease or condition resulting in death)		(or as a consequence		- (Sep.	>15.				
Examiner		Sequentially list conditions	, me	nigiti	5						
po iis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence of):						
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be ey sician buria				(or as a conseq.	acrice 61).						
P P lica	edical	8	d								
The law requires that the death certific the law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna		Te			23d. Date o	of delivery	
deatle atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)	·		Month	Day Year	
w requires that the d been signed by the should be detached	hys	9 ☐ Unknown					-				
res th igned be de	by F	Part II. Other significant conditions	s contributing to d	eath but not resi	ulting in the ur	nderlying cause give	en in Part I.			ite to the cause of death?	
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e law has b	nple							24a. Was a autop:	sy prio	re autopsy findings available or to completion of cause of	
			· · · · · · · · · · · · · · · · · · ·					perfor 1□ Yes		tth? Yes 2 □ No	
sician: The certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☐ No	Hospital:	effications 2.	ER/Outpatien	t 3D DOA Othe	er:	ath (Check only or			
g Phys er this		27. Manner of Death	28a. Date	of Injury	28b. Time of	1 JUDON	4 L Nursing		ence 6 □Other (ow injury occurred	(Specify)	
Attending Physician: r death. ector: After this certifics by the funeral director, I	ation	1 Natural 5 Pending 2 Accident investigat		nth, Day Year)	Injury		<br Yes 2 □ No				
r Atte er deg recto by th	Certification:	3 Suicide 6 Could not 4 Homicide determine	200, Flaut	e of injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number (or Rural Route Number,	
rs aft											
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying 2 Medical Ex	aminer; On the b	e best of my kno casis of examina nner stated.	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	ce, and due to the courred at the time, o	cause(s) and mann date and place, and	er as stated. d due to the cause(s)	
o the vithin of	Mec	29b. Signature and title of certifier	F Janu man	mer stateu.		29c. License	e number	2	29d. Date signed (#	Month, Day, Year)	
⊢≶⊢ŏ		> loule	(120.	mo		75	8510		_	7-08	
		30. Name and address of person wh	oppleted caus	se dideath (Item	1 23a) (Type,			01 Medica			
ILITY.		/	Stephy	Der	mo	and a c	Xo -	AAW	Annap	y oolis, MD 21401	

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^{Day} 27 Physician Month ^{Year} 2008 Tommy Lee March 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Apt 9 48 East Bel Air Avenue Harford Aberdeen
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo 3/4/1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Year) 1**☑**M 2□F Months Days Min 58 070-42-8409 Director New York Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 XYes 2 No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 East Bel Air Ave., Apt. by Funeral 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced ?7 is marked other than "natural", traumatic event, the Medi ai Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F James Lee ဥ Leola Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Patricia Lee (Spouse) 48 E. Bel Air Ave.Apt. 9, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Crematory 4/4/08 Brooklyn, NY 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CoRomary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ASCVD certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an has autopsy certificate 1□ Yes or Vital 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred neral Director: After filled in by the funera Certification: Division or Attending 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

ICARMA. 31. Date filed (Month, Day, Year) APR 0 4 2008

29b. Signature and title of certifier

NAIR, MD 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601.

1)20215

S. Umian Pous

29d. Date signed (Month, Day, Year)

Havredenace, no 21078

08-02152 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ONK UNK		State of N 1-For State Registrar	Maryland / Department o C <i>ertificate oi</i>		lygiene _{Reg}	No. 201	18 1000
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Roberto Rirell	Duiz Manting		2. Date of Death Month	Dav Year	3. Time of Death 0032 hrs
Medicai Exami	Hei	4a. Facility Name (if not institution, give street	Ruiz Martinez	4b. City, Town, or Location of Deat	March 17, 2	4c. County of Death	0032 Hrs
,		Route 18 at Bennett Point Roa	d	Queenstown		Queen Anne's	
Funeral Director		5. Social Security Number 6. Sex none 1 M	7. Age (In yrs. last birthday) 2 F 23 Yrs	Months Days Hours Mir		(MM/DD/YYYY) 9. Bird 1984	hplace (State or Foreign untry) Mexico
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	tion			10d. Inside City Limits
* .	ř	Md.	Annapolis				1 X Yes 2 No
with the Maryland ns 23a or 28a-f show pe notified at once.	Director	10e. Street and Number 1608 Revell Downs	Court	10f. Zip Code 21409	100	. Citizen of What Cour Mexico	ntry?
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f shr. rent, the Medical Examiner must be notified at once	Funeral					14. Race - Ameri White, etc.	can Indian, Black,
after d	by Fi	3 Widowed 4 Divorced If Yes	, Give Year 1 X	Yes 2 No specify: Me	xican	Specify: Wh	ite
2 hours afte "natural", Examiner	ted	15. Decedent's Education (Specify only hig Elementary/Secondary (0-12)	hest grade completed) 16a. Deceder during m	nt's Usual Occupation (Give kind of nost of working life, DO NOT use re		16b. Kind of Business/I	ndustry
5-0036 led within 72 Hygiene. other than the Medical	Completed	9th	Sings (1 1 di di)	Laborer		Mc Dona	1d
15-0 filed w Hygie d other		17. Father's Name (First, Middle, Last)		18.Mother's Nam	e (First, Middle, Ma	aiden Surname)	
Z = 4 = 5	To Be	Enrique Ruiz Guza 19a. Informant's Name/Relationship (Type, F		Virging Address (Street and Number or	ia Marti Rural Route Numb		. Zin Code)
re, MD 21; st and 2 should b f Health and Men ff item 27 is mar		Carmelo Ruiz Mart:	(DIUCHEI) 1600	Revell Downs Ct		polis, Md.	
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	20b. Place of Disposemoval from State crematory or ot	sition (Name of cemetery, ther place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Cemetery 03-	-27-08	Veracruz,	Mexico
Ba perm Depa Impo injur		Wanda C, Ba		3447 I4th street	al Home,	Inc.	DC 20010
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do not enter t	the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical		The same of the sa	ple Injuries				Death
		Sequentially list conditions, b.	o (or as a consequence of):				
	iner	if any, leading to immediate Due to cause. Enter Underlying Cause	o (or as a consequence of):				
ed nsit	Examiner	events resulting in death) Last	o (or as a consequence of):			-	
. 68760, ccrlificate be executed nding physician and ise as the burial - trans'		UNPENDED AME	ENDED				
760, icate be physic the burn	/Mec	IF FEMALE: 23c 23b. Was decedent pregnant in the	c. If yes, outcome of pregnancy			23d. Date of delivery	
SOX leath	Physician/Medical	past 12 months?	Drognant at time of death	etal death 3 Ectopic pregn ther (Specify)	ancy	Month E	Day Year
che the	by Ph	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	underlying cause given in Part I.		acco use contribute to	
e se se						2 ✓ No 3 Prob	Cartegay on com-
Law has	Completed	· · · · · · · · · · · · · · · · · · ·			24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of
	Be	25. Was case referred to medical examiner?		26.Place of Death (Check			
n of Viding Physic. After this funeral dir	은	1 Yes 2 No 27. Manner of Death	Ba. Date of Injury 28b. Time of I	- Land		esidence 6 Other	: Scene
C # 7 4 4	ij	1 Natural 5 Pending Investigation	Mar 17, 2008 ear) 0020 hrs	1 Yes 2 ✔ No	Driver in an a	uto to fixed object	t collision
Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: /	ertification:	3 Suicide 6 Could not be determined	8e. Place of Injury - At home, farm, stree Specify) Major Road / Highway	•		eet and Number or Ru te) nnett Point Road, Q	ral Route Number, City ueenstown, MD
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	one) 2 Medical Examiner: On the	the best of my knowledge, death occur be basis of examination and/or investigat nanner stated.				
To With Con	₩.	29b. Signature and title of certifier	namer states.	29c. License number		29d. Date signed (Mor	nth, Day, Year)
(3)		Hunek Youthell	no	O.C.M.E.		March 17, 2008	
ge		 Name and address of person who complete Pamela E. Southall, MD Ass 	·	1 Penn Street, Baltimore, I	MD 21201		
	ate	31. Date filed (Month, Day Year)	32. Registrar's Signature				
Regist	rar	MAR 1 9 2008	V 10				

DHMH 17 Rev 1/2001 OCME 2006

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5/3/1927 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F Months 577329129 Director 80 Usual Residence of Decedent 10a. State 10c, City, Town or Location 28a-f show Examiner must be notified at Director MD Prince George's Springdale 10e. Street and Number 10f. Zin Code 0 8926 Hobart St. 20774 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █\No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bultimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 X No þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within the Hygiene. 10th Swimming Pool Attendant tem 27 is marked other other traumatic event, t 17. Father's Name (First, Middle, Last) Be James Elsie 19a. Informant's Name/Relationship (Type, Print) Cheryl Edmonds/ Daughter 8926 Hobart St. Springdale, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages Department of Important: If it any injury or o once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 4 Donation 5 Dother (Specify) 21. Signature of curio ai S 7474 Landover Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia **Physician** /Medical Due to (or as a consequence of); Examiner Respiratory Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans <u>Metastatic Breast Cancer</u> Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Bilateral Pleural Effusion Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) signed by the a a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Diabetes Mellitus Completed Hypertenstion certificate has b irector, page 2 sl Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of

1. Decedent's Name (First, Middle, Last)

Bullock

McMillan

Physician

/Medical

Gov't 18. Mother's Name (First, Middle, Maiden Surname) Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3/19/2008 Washington,DC 22. Name and Address of Facility J.B. Jenkins Funeral Home Landover, MD 20785 Approximate Interval Between Onset and Death MINS hrs 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 12700 Good loes Promise Dr. Bowie, md, 20120

To the Hospital c within 24 hours af To the Funeral D completely filled i

after death Director:

filled in by

Medical

State Registrar

31. Date filed (Month, Day, Year) MAR 1 9 2008

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

hatsion 6. Mehari MD

of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Mourch 1

3,2008

4c. County of Death

10g. Citizen of What Country?

USA

Prince George's

14. Race - American Indian,

Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

1:40 PM

Birthplace (State or Foreign Country)

Washington, DC

10d. Inside City Limits

1 X Yes 2 □ No

Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar		artment of F rtificate of			20	00 1000
г	(il., 10)	-	Registrar 1. Decedent's Name (First, Middle, Las	st)	Cel	lineale or	Dealli	2. Date of Death	ng. No. 🚄 🕖	3. Time of Death
*	Physici /Medi		Forrest Alfred	Myers				Month Marc	Day Ch 18, 2	Year
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County of	
4		à	Holy Cross Hospi				Spring			Montgomery
è	Funeral		5. Social Security Number 6. Se	ex 7. Age (a 【☐M2☐F	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,		Birthplace (State or Foreign Country)
-	Director		Usual Residence of Decedent		88			July 7,	1919	Massachusetts
	yland now at		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Sa-f sl	Director	Maryland Mc	ontgomery	Silv	ver Sprin	ıq			1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	hat Country?
	s 23a	eral	1135 University			209			US	
10	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? M√Yes 2 □ No	er in U.S. 13. V	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		- American Indian, . , White, etc.
036	al", o	δ	3 Widowed 4 □ Divorced	M⊋Yes 2 □ No If Yes, Give Year or Dates:	WWII	I∐Yes 2√□No	Specify:		Specify:	White
5-0	72 hc 'natur dical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup	ation during most of wo	rkina 1	6b. Kind of Busi	iness/Industry
121	vithin one. chan '	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o	1)	9		
d 2	filed v Hygie ther i	ပ္ပ	17. Father's Name (First, Middle, Last)		Ma	anager	18. Mother's Nar	ne (First, Middle, M	estauran Jaiden Surname	
lan	ld be ental ked o ic eve	To Be	Friedrich Mears					indsor	arcon Carname,	,
Maryland 21215-0036	shou and M s mar	-	19a. Informant's Name/Relationship (7	Гуре. Print)	19b. Mailin	g Address (Street		ıral Route Number,	City or Town, S	tate, Zip Code)
Σ	and 2 salth a n 27 is		William Myers/Son					ve, Silve	er Sprin	ng, MD 20906
Baltimore,	ges 1 of He if iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place	ce) Mar	Date 20,	Oc. Location - C	City or Town, State
ţ	t. Pactiment:		4 Donation 5 Dother (Specify)	Metropolit	an Crema	tory	2008 A	lexandr	ria, Virginia
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	rieWar	Mr 50	Name and Address rancis J. 00 Univer	ss of Facility Collins sity Blv	Funeral	Home In Silver S	nc. Spring, MD 2090
Ľ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the	e death. Do not ente	er the mode of dyin	ng, such as cardia	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Myocardia	al Infarct	ion				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):					
		-e	Sequentially list conditions, if any, leading to immediate	b. Lung Cand						_
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
o	an an	Exa	resulting in death) Last	Due to (or as a co	onsequence of):	 -				
68760,	ficate be executed physician and s the burial-transit	edical		.d						
_		Med	IF FEMALE:	23c. If yes, outcome pf p	prograncy					
Вох	The law requires that the death certific te has been signed by the attending in age 2 should be detached for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
P.O.	that the de led by the a detached f	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ic or death o i	TOttlet (specify)				
	res that signed b	by PI	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contrib	oute to the cause of death?
ord	w require been sig should b							1 ☐ Yes	3 2 □ No 3	☐ Probably 4 ☐ Unknown
Vital Records,	has be	Completed						24a. Was an autopsy		ere autopsy findings available for to completion of cause of
E H		Sol						perform	ed? dea	ath? ⊒Yes 2∐ No
<u> </u>	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	or.	th (Check only one		
ō	ding Phys h. After this funeral dir	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2K ER/Outpatient 28b. Time of	28c. Injun Work	4 ∟ Nursing H	ome 5 Residen		
<u>o</u>	ath. r: Afte e fune	atior	1 Natural 5 Pending investigation	(Month, Day Ye	ear) Injury		<br Yes 2 □ No		,,,,,,	
Division or	i or Attending Physician: after death. Director: After this certification by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (\$	- At home, farm, stre Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Number	or Rural Route Number,
	oital or A			le le le le le le le le le le le le le l					,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 ☑ CertifyIng Phy 2 ☐ Medical Exam	sician: To the best of m iner: On the basis of ex- and manner stated	amination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	e, and due to the cau irred at the time, da	use(s) and mann te and place, an	ner as stated. Indicate due to the cause(s)
	To t withi To tl	ž	29b. Signature and title of certifier	/		29c. License				Month, Day, Year)
) ,	3 1 1		7.13dm	0 - 9			4792			12008
	3+1		30. Name and address of person who c Lila Bahadori, M	ompleted cause of death D 1500 F	(Item 23a) (Type, F 'orest Gle	en Road,	Silver S	pring, MD	20910	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2 1 2	32. Pi gistrar's	Signature	nerte				

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			For State Registrar	State of	Maryland		irtment of <i>tificate of</i>	Health and ^f <i>Death</i>	Mental Hy	/giene Reg. No. 2	108	10999
P	Physici	an	1. Decedent's Name (First, Midd						2. Date of D Month	eath Day	Year	3. Time of Death
156	/Medio	al .	Doris Aleda Myers 4a. Facility Name (If not institution		ber)		4b. City, Town,	or Location of Dea		farch 20, 20	08 by of Death	10:12 PM ^M
			23 High Street					Frostburg		Alleg	gany	
	uneral rector	ŭ	5. Social Security Number 217-28-2302	6. Sex 1 □ M 2 ▼ F	7. Age (In yrs. Ia 76	st birthday) Yrs.	If Under 1 Yea Months Days		n. (Month, D	rth ay, Year) ber 28, 1931	9. Birth Cou Ma	place (State or Foreign intry) ryland
yland	at		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Lo	cation					10d. Inside City Limits
le Mar	a or 28a-f show be notified at	Director		legany	Fro	stburg						1 X Yes 2 No
with th	a or 2 t be no	Dire	10e. Street and Number 23]	High Street			10f. Zip Code			10g. Citizen of	What Cou	intry?
1215-0036 within 72 hours after death with the Maryland ene.	"natural", or items 23a edical Examiner must k	by Funeral	11. Marital Status 1 □ Never Married 2 Mar 3 □ Widowed 4 □ Dvorced	ried Armed Ford	No No		21532- Vas Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N erto Rican, etc.)	U.S.A. 14. Ra Bla Speci	ick, White,	
Maryland 21215-0036 to 2 should be filed within 72 hours after and Mental Hygiene.	If Item 27 is marked other than "natura or other traumatic event, the Medical E.	Completed I	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-		(Give life. E		Occupation fone during most of working etired)		16b. Kind of E	Wh Business/Ir	
be filed wintal Hygier	ther th nt, the		12 17. Father's Name (<i>First, Middle,</i>	l act)		nome	maker	19 Mothoda Na	ame (First, Middle	homem		
Aaryland 2	rked or	To Be	John Harrison Lev					Inez Ric		, Maiden Surna	ne)	
lary 2 shot and N	is mar aumat		19a. Informant's Name/Relations		_	19b. Mailin	g Address (Stree	et and Number or F	Rural Route Numi	per, City or Town	, State, Zi	p Code)
e, No 1 and Health	em 27 ther to		Paul E. Myers 20a. Method of Disposition	husban			ch Street sition (Name of	F1	rostburg Date	Mar 20c. Location	yland	21532-
Baltimore, Maperinit. Pages 1 and 2 Department of Health 8	ant: If It ury or o		1 Surial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from Si Specify)		metery, cren	natory or other pl rt Cemetery		larch 25, 2008	Eckhart	-	aryland
Balt permit. Depart	Important: any injury once.		21. Signature of Funeral Service	Licensee	1	22	Name and Add	ess of Facility	7 Frost Ave	Frosthur	· MD	21532
2. (3)	physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate bases. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a conseque r as a conseque r as a conseque	ence of):						
u	igned by the attending phys be detached for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		th 2□Fetald nt at time of dea	leath 3 🗌	Ectopic pregnan Other (specify) _	су			ate of delive	ery Day Year
ds, F	signed of be de	ک	Part II. Other significant condition	ons contributing to dea	th but not resulti	ing in the un	derlying cause gi	ven in Part I.				he cause of death?
	certificate has been signector, page 2 should t	Completed							24a. Was	an 24b. psy prmed?	Were auto prior to co death?	opsy findings available impletion of cause of
· Vit	is certili directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	oatient 2□EF	3/Outnatient	3□ DOA Ot	hor	ath (Check only		- 12	
E g 4	Arrer tr funeral		27. Manner of Death 1 Annur of Death 2 Accident 5 Pendin	28a. Date of (Month,		8b. Time of Injury	28c. Inju		Home 5 Peribe	how injury occur		<u>59) </u>
Division To the Hospital or Attending within 24 hours after death.	completely filled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of building	f injury - At home g, etc. <i>(Specify)</i>				City or To	wn, State)		al Route Number,
e Hosk	letely f	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medicai	g Physician: To the b Examiner: On the bas and manne	is of examinatio	edge, death n and/or inv	occurred at the t estigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and made and place,	anner as s and due t	tated. o the cause(s)
To th within	сошр	Me	29b. Signature and title of certifier	r			29c. Licen			29d. Date signe	d (Month,	Day, Year)
)	6			Syllow			126	907		MARC	17 24	,2008
n	128		30. Name and address of person HARTH Sidhu	725 B	Shop a	U8/5/	Piz_	Combe	CHND	mD	2	1502
R	Sta legistra		31. Date filed (Month, Pry Sar)	2008	gistrar's/Signatur	k d	and,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 7:25 AM Miller 3 0 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney-Keedy Nursing Home Boonsboro Washington 8. Date of Birth (Month, Day, Yea March 14, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) v^{Year)}1915 **Funeral** Days Hours 1□M 2□ 215-34-3772 93 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Frederick Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8004 Clearfield Road 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ĀZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed by XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Milton Free Estie Mae Kline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Wellington, daughter 5140 Volusia Ave., Titusville, Flordia 20a. Method of Disposition
14 Buriat 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Rocky Springs Cemetery April 4, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signator of Pueral Service Libersee ^{22. N}Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on Ach line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cap Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition nenmonia **Physician** W resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as the ed by the attending detached for use as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/1 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔁 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid Waseem, M.D., 1126 Opal Court, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

5 DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Clarence James McConnel 26, March 2008 7:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Caroline Home for Hospice Denton Caroline Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 3 M 2 □ F 6.5 231-54-1896 Director Sept. 18, 1942 Marvland Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Caroline Federalsburg Director 1 ☐ Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or ; must be n 27960 Liberty Road 21632 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mi once. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 🔀 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Radiology Engineer Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carol John McConnel Shirley Irene Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn McConnel/Spouse 27960 Liberty Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mid Shore Cre.Ctr. 3/28/08 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, CFSP 23a. Part1. Enter the disease, or complications t/a) caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus / or leach ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed 2 No 1 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospite House 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death
 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a To the Funeral I 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the and manner stated. 29b. Signature and of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. David Smith 8221 Easton, IND 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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